

BUREAU V. S.

JAN 11 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL - EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY	Allegany		STATE	Md.	
CITY (If outside corporate limits, write RURAL and give nearest town)	TOWN		CITY (If outside corporate limits write RURAL and give nearest town)	TOWN	
	Cumberland			Flintstone	
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS		
Dead on arrival at the Memorial Hospital.			R.F.D. #4 Box 369		
3. NAME OF DECEASED:			4. DATE OF DEATH		
(First)	(Middle)	(Last)	(Month)	(Day)	(Year)
James	Walter	Ash	Jan.	25	19 56
5. SEX:		6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		
male		white	married		
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.	
Janitor at the Goodfellowship Club		Club		63 yrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country):			12. CITIZEN OF WHAT COUNTRY?		
Flintstone, Md.			U.S.A.		
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
James Jackson Ash			Jennie Diehl		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY No.:		
Yes ✓ W.W.I			220-10-8673		
17. INFORMANT & ADDRESS:			18. MEDICAL CERTIFICATION		
(nephew) Herbert Ash, Flintstone, Md.			INTERVAL BETWEEN ONSET AND DEATH		

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			20. AUTOPSY?		
Immediate cause (a) Coronary occlusion			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
Antecedent cause(s) (b) Coronary sclerosis			?		
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)					
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:			19b. MAJOR FINDING OF OPERATION:		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY			21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE			CHIEF MEDICAL EXAMINER		
H.V. Deming M.D.			DATE SIGNED		
H.V. Deming M.D.			Jan. 26 - 1956		
23. BURIAL, CREMATION, REMOVAL (Specify):			24. FUNERAL DIRECTOR		
Burial			James H. Scarfelli, Cumberland, Md.		
DATE REC'D BY LOCAL REG.			ADDRESS		
Jan. 27, 1956			Winter L. Frantz, M.D.		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 30 1966
BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegheny</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegheny</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>7 days</u>		TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u>				STREET ADDRESS (If rural give location) <u>333 Virginia St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Mary</u> (Middle) <u>Virginia</u> (Last) <u>Barrett</u>				(Month) <u>1/2</u> (Day) <u>56</u> (Year) <u>19</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>W</u>	<u>Widowed</u>	<u>1/23/1895</u>	<u>60</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Own home</u>		<u>Virginia</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>David Smith</u>				<u>Emma Bush Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Mrs. Phyllis McGaughey City</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Uremia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pyelonephritis & nephrosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Diabetes - Acidosis</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>General arteriosclerosis</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/26</u> , 19 <u>55</u> , to <u>1/2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/1</u> , 19 <u>56</u> , and that death occurred at <u>1:50</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Hauensman</u>				ADDRESS (Street, city, town, state) <u>59 Greene St Cumberland</u> DATE SIGNED <u>1/3/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>I-5-56</u>		<u>Davis Mem. Cem.</u>		<u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
<u>Jan 4, 1956</u>		<u>W.R. Hantz, M.D.</u>		<u>James F. Scarpelli Cumberland, Md.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 104

RECEIVED

JAN 6 1918

BUREAU V. S.

1. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		2. PLACE OF DEATH	
3. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		4. PLACE OF DEATH	
5. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		6. PLACE OF DEATH	
7. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		8. PLACE OF DEATH	
9. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		10. PLACE OF DEATH	
11. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		12. PLACE OF DEATH	
13. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		14. PLACE OF DEATH	
15. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		16. PLACE OF DEATH	
17. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		18. PLACE OF DEATH	
19. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		20. PLACE OF DEATH	
21. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		22. PLACE OF DEATH	
23. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		24. PLACE OF DEATH	
25. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		26. PLACE OF DEATH	
27. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		28. PLACE OF DEATH	
29. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		30. PLACE OF DEATH	
31. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		32. PLACE OF DEATH	
33. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		34. PLACE OF DEATH	
35. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		36. PLACE OF DEATH	
37. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		38. PLACE OF DEATH	
39. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		40. PLACE OF DEATH	
41. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		42. PLACE OF DEATH	
43. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		44. PLACE OF DEATH	
45. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		46. PLACE OF DEATH	
47. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		48. PLACE OF DEATH	
49. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		50. PLACE OF DEATH	
51. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		52. PLACE OF DEATH	
53. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		54. PLACE OF DEATH	
55. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		56. PLACE OF DEATH	
57. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		58. PLACE OF DEATH	
59. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		60. PLACE OF DEATH	
61. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		62. PLACE OF DEATH	
63. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		64. PLACE OF DEATH	
65. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		66. PLACE OF DEATH	
67. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		68. PLACE OF DEATH	
69. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		70. PLACE OF DEATH	
71. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		72. PLACE OF DEATH	
73. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		74. PLACE OF DEATH	
75. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		76. PLACE OF DEATH	
77. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		78. PLACE OF DEATH	
79. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		80. PLACE OF DEATH	
81. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		82. PLACE OF DEATH	
83. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		84. PLACE OF DEATH	
85. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		86. PLACE OF DEATH	
87. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		88. PLACE OF DEATH	
89. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		90. PLACE OF DEATH	
91. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		92. PLACE OF DEATH	
93. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		94. PLACE OF DEATH	
95. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		96. PLACE OF DEATH	
97. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		98. PLACE OF DEATH	
99. USUAL RESIDENCE (HOME OR PLACE OF BIRTH)		100. PLACE OF DEATH	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

3001272727

1
Within Corporate Limits.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00004

CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEGANY</u>		STATE <u>MARYLAND</u> COUNTY <u>ALLEGANY</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>CUMBERLAND</u>		LENGTH OF STAY (in this place) <u>7 days</u>		TOWN <u>CUMBERLAND</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SACRED HEART HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>339 FREDERICK STREET</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ELLA</u>		(Middle) <u>ELIZABETH</u>		(Last) <u>BECKWARD</u>		1-20-56 19	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>5-15-21</u>	9. AGE last birthday <u>34</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Elevator Opr.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rosebaum Dept. Store</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND, Cumberland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN JONES X Stephens, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>HILDA Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-16-5220</u>		17. INFORMANT & ADDRESS <u>CHART</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
330X IMMEDIATE CAUSE (A) <u>Subarachnoid Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 13, 1956</u> , to <u>Jan 20, 1956</u> , that I last saw the deceased alive on <u>Jan 20, 1956</u> , and that death occurred at <u>10:45</u> M, from the causes and on the date stated above.							
SIGNATURE <u>B. M. Schneider</u>		M.D. <u>41 Greenville</u>		ADDRESS (Street, city, town, state) <u>Cumberland, Md.</u>		DATE SIGNED <u>1/21/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 23, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		LOCATION (City, town, or county) <u>Cumberland, Maryland</u>	
24. REC'D BY REGISTRAR <u>Jan 23, 1956</u>		REGISTRAR'S SIGNATURE <u>Walter A. Brantley M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hafer</u>		ADDRESS <u>Funeral Service, Cumberland</u>	

1956

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

CERTIFICATE OF DEATH

Reg. No. 12

1. NAME OF DECEASED (Print or Write)

2. SEX

3. AGE

4. PLACE OF BIRTH

5. DATE OF BIRTH

6. PLACE OF DEATH

7. OCCUPATION

8. CAUSE OF DEATH

9. MEDICAL ATTENDANCE

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CORONER

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF CLERK

17. SIGNATURE OF REGISTRAR

18. SIGNATURE OF SHERIFF

19. SIGNATURE OF SHERIFF'S DEPUTY

20. SIGNATURE OF SHERIFF'S CLERK

21. SIGNATURE OF SHERIFF'S JURY

22. SIGNATURE OF SHERIFF'S JUDGE

23. SIGNATURE OF SHERIFF'S CLERK

24. SIGNATURE OF SHERIFF'S SHERIFF

25. SIGNATURE OF SHERIFF'S DEPUTY

26. SIGNATURE OF SHERIFF'S CLERK

27. SIGNATURE OF SHERIFF'S JURY

28. SIGNATURE OF SHERIFF'S JUDGE

29. SIGNATURE OF SHERIFF'S CLERK

30. SIGNATURE OF SHERIFF'S SHERIFF

31. SIGNATURE OF SHERIFF'S DEPUTY

32. SIGNATURE OF SHERIFF'S CLERK

33. SIGNATURE OF SHERIFF'S JURY

34. SIGNATURE OF SHERIFF'S JUDGE

35. SIGNATURE OF SHERIFF'S CLERK

36. SIGNATURE OF SHERIFF'S SHERIFF

37. SIGNATURE OF SHERIFF'S DEPUTY

38. SIGNATURE OF SHERIFF'S CLERK

39. SIGNATURE OF SHERIFF'S JURY

40. SIGNATURE OF SHERIFF'S JUDGE

41. SIGNATURE OF SHERIFF'S CLERK

42. SIGNATURE OF SHERIFF'S SHERIFF

43. SIGNATURE OF SHERIFF'S DEPUTY

44. SIGNATURE OF SHERIFF'S CLERK

45. SIGNATURE OF SHERIFF'S JURY

46. SIGNATURE OF SHERIFF'S JUDGE

47. SIGNATURE OF SHERIFF'S CLERK

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105. SIGNATURE OF SHERIFF'S JURY

106. SIGNATURE OF SHERIFF'S JUDGE

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109. SIGNATURE OF SHERIFF'S DEPUTY

110. SIGNATURE OF SHERIFF'S CLERK

111. SIGNATURE OF SHERIFF'S JURY

112. SIGNATURE OF SHERIFF'S JUDGE

113. SIGNATURE OF SHERIFF'S CLERK

114. SIGNATURE OF SHERIFF'S SHERIFF

115. SIGNATURE OF SHERIFF'S DEPUTY

116. SIGNATURE OF SHERIFF'S CLERK

117. SIGNATURE OF SHERIFF'S JURY

118. SIGNATURE OF SHERIFF'S JUDGE

119. SIGNATURE OF SHERIFF'S CLERK

120. SIGNATURE OF SHERIFF'S SHERIFF

BUREAU V. S.

JAN 24 1956

RECEIVED

NOTED

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY <u>Allegany</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u> 23 yrs. HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1027 Penhurst Street</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Allegany</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u> STREET ADDRESS (If rural give location) <u>1027 Penhurst Street</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Anne</u> (Middle) <u>Halterman</u> (Last) <u>Beery</u>		4. DATE OF DEATH (Month) <u>1</u> (Day) <u>15</u> (Year) <u>19 56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Sept. 5, 1910</u>
9. AGE last birthday <u>45</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Moorefield, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jehu Halterman</u>		14. MOTHER'S MAIDEN NAME <u>Ersula Simmons</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>214-07-4236</u>	
17. INFORMANT & ADDRESS <u>Russell D. Beery, Cumberland, Md</u>			
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>198X</u> IMMEDIATE CAUSE (A) <u>Carcinomatosis primary</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>auto retractorial</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>One</u> <u>Month</u>
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>—</u>			
19a. DATE OF OPERATION <u>9/21/55</u>		19b. MAJOR FINDINGS OF OPERATION <u>Large peritoneal mass (malignant)</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Hour) (Minute) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>—</u>	
22. I hereby certify that I attended the deceased from <u>12/4/55</u> , 19 <u>55</u> , to <u>1/15/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/14/56</u> , 19 <u>56</u> , and that death occurred at <u>—</u> M, from the causes and on the date stated above. SIGNATURE <u>Richard J. Halterman</u> M.D. ADDRESS (Street, city, town, state) <u>122 S. Centre Cumberland, Md.</u> DATE SIGNED <u>1/16/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>Jan. 18, 56</u>	
25. REGISTRAR'S SIGNATURE <u>Walter R. Frank, M.D.</u>		26. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarvelli</u>	
27. ADDRESS <u>Cumberland, Md.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

1

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00006

88

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		MARYLAND		STATE Maryland		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
X TOWN Lonaconing				TOWN Lonaconing		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
25				Douglas Avenue			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Louise		(Middle) W		(Last) Bell		(Month) (Day) (Year)	
						Jan 22 19 56	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
Female	White	Widowed	Feb 21, 1870	85 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Retired Teacher		Public School		Germany		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Carl Weisenthal				Louise Petry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no				Margaret Sloan Lonaconing, Md			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A)				Daughter		2 hrs -	
ANTECEDENT CAUSE(S) DUE TO				Congestive Heart Failure			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				Coronary Heart Disease		3 y.	
				Arteriosclerosis		5-10 y.	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 1952 , to 1/22 , 19 56 , that I last saw the deceased alive on 1/22 , 19 56 , and that death occurred at 10:24 AM, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
George Richardson				Lonaconing, Md		1/23/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Jan 24, 1956		Oak Hill		Lonaconing Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 1-24-56		Jannette M Bood		George Eichhorn		Lonaconing, Md.	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED

MARYLAND

COUNTY OF

CITY OF

STREET

APRIL 1, 1956

AGE

SEX

RACE

EDUCATION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF EXAMINATION

PLACE OF EXAMINATION

NAME OF EXAMINER

DATE OF SIGNATURE

PLACE OF SIGNATURE

NAME OF SIGNER

DATE OF SIGNATURE

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NAME OF SIGNER

DATE OF SIGNATURE

PLACE OF SIGNATURE

BUREAU V. 2

JAN 30 1956

RECEIVED

INSTRUCTIONS

1. This certificate is to be filled out by the physician or other qualified person who has attended the deceased or who has examined the body after death. It should be filled out as soon as possible after death and should be filed in the office of the health officer of the county or city in which the death occurred. It should be filled out in duplicate and one copy should be sent to the State Department of Health, Baltimore, Maryland. The other copy should be retained in the office of the health officer. The certificate should be filled out in the following manner: 2. Name of deceased: Give the full name of the deceased as it appears on the birth record. 3. Sex: Give the sex of the deceased. 4. Race: Give the race of the deceased. 5. Education: Give the highest grade of school completed. 6. Occupation: Give the occupation of the deceased. 7. Date of birth: Give the date of birth of the deceased. 8. Place of birth: Give the place of birth of the deceased. 9. Date of death: Give the date of death of the deceased. 10. Place of death: Give the place of death of the deceased. 11. Cause of death: Give the cause of death of the deceased. 12. Manner of death: Give the manner of death of the deceased. 13. Date of examination: Give the date of examination of the body. 14. Place of examination: Give the place of examination of the body. 15. Name of examiner: Give the name of the examiner. 16. Date of signature: Give the date of signature of the examiner. 17. Place of signature: Give the place of signature of the examiner. 18. Name of signer: Give the name of the signer. 19. Date of signature: Give the date of signature of the signer. 20. Place of signature: Give the place of signature of the signer.

CERTIFICATE OF DEATH

Item 9, Film G191 1-18-56 et

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEGANY</u>		STATE <u>MARYLAND</u> COUNTY <u>ALLEGANY</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		TOWN		TOWN	
TOWN <u>CUMBERLAND</u>		20 hrs		CUMBERLAND		02	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u>				STREET ADDRESS (If rural give location) <u>173 N. Mechanic</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>CECIL CARL BLACKBURN</u>				<u>7 19 56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>6-15-09</u>	9. AGE last birthday <u>46</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer Brick Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jess Blackburn</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Marshall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>836-03-0129</u>		17. INFORMANT & ADDRESS <u>Cleda M. Blackburn</u> <u>Old Chart 173 N. Mechanic St.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
581.0 IMMEDIATE CAUSE (A) <u>Sub B - Cirrhosis of liver</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>A - Hematemesis</u>				<u>24 hours</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 3</u> , 19 <u>56</u> , to <u>Jan 4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 3</u> , 19 <u>56</u> , and that death occurred at <u>6:01 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>R. M. Trevasch, Jr.</u> M.D. <u>Cumberland</u>				DATE SIGNED <u>9th 1/5/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/6/56</u>		NAME OF CEMETERY OR CREMATORY <u>Porter Cemetery</u>		LOCATION (City, town, or county) (State) <u>Ellerslie, Md.</u>	
24. REC'D BY REGISTRAR <u>Jan 6, 1956</u>		REGISTRAR'S SIGNATURE <u>Walter R. Trantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. Lee Silcox - Cumberland, Md.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of the death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

00008

Reg. Dist. No. 4

6
Within corporate limits

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberland</u>		LENGTH OF STAY (in this place) <u>2mo. 12 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberladd</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sylvan Retreat</u>				STREET ADDRESS <u>211 Carroll</u> (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Ulysses</u>		(Middle) <u>R</u>		(Last) <u>Bromery</u>		(Month) (Day) (Year) <u>Jan. 9 19 56</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 10, 1877</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired train porter</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Daniel Bromery</u>				14. MOTHER'S MAIDEN NAME <u>Frances Harber</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Sylvan Retreat Cumberland, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>592X</u> <u>arterio Sclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral Arteriosclerosis</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Chronic Nephritis</u>						<u>?</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senile psychosis</u>						<u>37 mos.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 5, 1955</u> to <u>Jan. 9, 1956</u> , that I last saw the deceased alive on <u>Jan 7th, 1956</u> , and that death occurred at <u>8:45 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James B. McLean</u>		M.D.		ADDRESS (Street, city, town, state) <u>49 Greene St.</u>		DATE SIGNED <u>1-9-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/11/56</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>1-11-56</u>		REGISTRAR'S SIGNATURE <u>W. R. Brantley M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein, Inc.</u> ADDRESS <u>Cumberland, Md.</u>			

5. A. OVERVIEW

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00009

CERTIFICATE OF DEATH

Reg. Dist. No.

89

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Rural, Rt. 1, Flintstone</u>				TOWN <u>Rt. 1, Flintstone</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rt. 1, Flintstone</u>				STREET ADDRESS (If rural give location) <u>Rt. 1, Flintstone</u>			
3. NAME OF DECEASED (Type or Print) <u>DORA</u> (First) <u>EFFIE</u> (Middle) <u>BROWNING</u> (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>January 3</u> 19 <u>56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 23, 1891</u>		9. AGE last birthday <u>64</u> yrs.	IF UNDER 1 YEAR (Month) (Day) (Year) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JACOB B. BENDER</u>				14. MOTHER'S MAIDEN NAME <u>JULIA TWIGG</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>A.T. Browning, Rt. 1, Flintstone, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Cerebrovascular accident</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Heart disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Generalized arteriosclerosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hypertension</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept</u> , 19 <u>51</u> , to <u>11/3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec</u> , 19 <u>55</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>George M. Brown</u>				ADDRESS (Street, city, town, state) <u>Cumberland, Md</u>		DATE SIGNED <u>11/3/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 5, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>IOOF Cemetery</u>		LOCATION (City, town, or county) <u>Flintstone, Maryland</u>	
24. REC'D BY REGISTRAR <u>Jan 6, 1956</u>		REGISTRAR'S SIGNATURE <u>Anna L. Bender</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer</u>		ADDRESS <u>Cumberland, Maryland</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

1. PLACE OF DEATH:

COUNTY Allegany MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Cumberland
 LENGTH OF STAY (in this place) 1 yr.

HOSPITAL OR INSTITUTION OR STREET ADDRESS 219 Pear St.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegany

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Cumberland

STREET ADDRESS (If rural, give location) 219 Pear St.

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

DorothyMaeBull

4. DATE OF DEATH

(Month)

(Day)

(Year)

Jan.2319 56

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

femaleWhiteMarriedMarch 22-192926

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):

Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

Own Home

11. BIRTHPLACE (State or foreign country):

Ridgely, W. Va.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME:

Siple VanMeter Rumer

14. MOTHER'S MAIDEN NAME:

Lola Dawson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

no

16. SOCIAL SECURITY No.:

None

17. INFORMANT & ADDRESS:

(husband) John R. Bull, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a)

Coronary occlusion

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

Coronary sclerosis.

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH
sudden

about 1 year.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

DEPUTY MEDICAL EXAMINER ☐M. D. ASSISTANT MEDICAL EXAM. ☐1-23-1956

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Jan. 25, 1956Walter R. Frank, M.D.Charles L. George, Cumberland, Md.near Keyser West Virginia

RECEIVED

JAN 26 1956

BUREAU V. S.

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

90

CERTIFICATE OF DEATH

00011

Reg. Dist. No. 8

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		MARYLAND		STATE Maryland		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Lonaconing				TOWN Midland			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Mary (Middle) Bullock (Last)				(Month) Jan (Day) 3 (Year) 19 56			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
Female	White	Widowed	Nov 24, 1887	68 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
House Work		Own Home		Lithuanian		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Unknown				Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no (If Yes, give war or dates of service)				Peter Bullock Midland, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) Coronary Occlusion				INTERVAL BETWEEN ONSET AND DEATH 2 min.			
ANTECEDENT CAUSE(S) DUE TO (B) Myocardial Infarction				2 weeks			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Arteriosclerotic Cardiovascular Disease				4-5 yrs			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 19 55 , to 3 Jan 19 56 , that I last saw the deceased alive on 3 Jan 19 56 , and that death occurred at 8:55 M., from the causes and on the date stated above.		SIGNATURE George Richards		ADDRESS (Street, city, town, state)		DATE SIGNED 1/4/56	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		1/7/56		St Micheals		Frostburg, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 1-5-56		Joanette M. Boal		George Eichhorn		Lonaconing, Md.	

CERTIFICATE OF DEATH

20

REG. GEN. NO.

1. USUAL RESIDENCE THOMAS ON HIGGARD

2. PLACE OF DEATH

3. SEX AND

4. AGE

5. RACE

6. OCCUPATION

7. CAUSE OF DEATH

8. DATE OF DEATH

9. TIME OF DEATH

10. SIGNATURE

11. PLACE OF BIRTH

12. DATE OF BIRTH

13. TIME OF BIRTH

14. SIGNATURE

15. PLACE OF BIRTH

16. DATE OF BIRTH

17. TIME OF BIRTH

18. SIGNATURE

19. PLACE OF BIRTH

20. DATE OF BIRTH

21. TIME OF BIRTH

22. SIGNATURE

23. PLACE OF BIRTH

24. DATE OF BIRTH

25. TIME OF BIRTH

26. SIGNATURE

27. PLACE OF BIRTH

28. DATE OF BIRTH

29. TIME OF BIRTH

30. SIGNATURE

31. PLACE OF BIRTH

32. DATE OF BIRTH

33. TIME OF BIRTH

34. SIGNATURE

35. PLACE OF BIRTH

36. DATE OF BIRTH

37. TIME OF BIRTH

38. SIGNATURE

39. PLACE OF BIRTH

40. DATE OF BIRTH

41. TIME OF BIRTH

42. SIGNATURE

43. PLACE OF BIRTH

44. DATE OF BIRTH

45. TIME OF BIRTH

46. SIGNATURE

1. USUAL RESIDENCE

2. PLACE OF DEATH

3. SEX AND

4. AGE

5. RACE

6. OCCUPATION

7. CAUSE OF DEATH

8. DATE OF DEATH

9. TIME OF DEATH

10. SIGNATURE

11. PLACE OF BIRTH

12. DATE OF BIRTH

13. TIME OF BIRTH

14. SIGNATURE

15. PLACE OF BIRTH

16. DATE OF BIRTH

17. TIME OF BIRTH

18. SIGNATURE

19. PLACE OF BIRTH

20. DATE OF BIRTH

21. TIME OF BIRTH

22. SIGNATURE

23. PLACE OF BIRTH

24. DATE OF BIRTH

25. TIME OF BIRTH

26. SIGNATURE

27. PLACE OF BIRTH

28. DATE OF BIRTH

29. TIME OF BIRTH

30. SIGNATURE

31. PLACE OF BIRTH

32. DATE OF BIRTH

33. TIME OF BIRTH

34. SIGNATURE

35. PLACE OF BIRTH

36. DATE OF BIRTH

37. TIME OF BIRTH

38. SIGNATURE

39. PLACE OF BIRTH

40. DATE OF BIRTH

41. TIME OF BIRTH

42. SIGNATURE

43. PLACE OF BIRTH

44. DATE OF BIRTH

45. TIME OF BIRTH

46. SIGNATURE

47. PLACE OF BIRTH

48. DATE OF BIRTH

49. TIME OF BIRTH

50. SIGNATURE

51. PLACE OF BIRTH

52. DATE OF BIRTH

53. TIME OF BIRTH

54. SIGNATURE

55. PLACE OF BIRTH

56. DATE OF BIRTH

57. TIME OF BIRTH

58. SIGNATURE

59. PLACE OF BIRTH

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61. TIME OF BIRTH

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71. PLACE OF BIRTH

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74. SIGNATURE

75. PLACE OF BIRTH

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93. TIME OF BIRTH

94. SIGNATURE

95. PLACE OF BIRTH

96. DATE OF BIRTH

97. TIME OF BIRTH

98. SIGNATURE

99. PLACE OF BIRTH

100. DATE OF BIRTH

101. TIME OF BIRTH

102. SIGNATURE

103. PLACE OF BIRTH

104. DATE OF BIRTH

105. TIME OF BIRTH

106. SIGNATURE

107. PLACE OF BIRTH

108. DATE OF BIRTH

109. TIME OF BIRTH

110. SIGNATURE

111. PLACE OF BIRTH

112. DATE OF BIRTH

113. TIME OF BIRTH

114. SIGNATURE

115. PLACE OF BIRTH

116. DATE OF BIRTH

117. TIME OF BIRTH

118. SIGNATURE

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120. DATE OF BIRTH

121. TIME OF BIRTH

122. SIGNATURE

123. PLACE OF BIRTH

124. DATE OF BIRTH

125. TIME OF BIRTH

126. SIGNATURE

127. PLACE OF BIRTH

128. DATE OF BIRTH

129. TIME OF BIRTH

130. SIGNATURE

131. PLACE OF BIRTH

132. DATE OF BIRTH

133. TIME OF BIRTH

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140. DATE OF BIRTH

141. TIME OF BIRTH

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143. PLACE OF BIRTH

144. DATE OF BIRTH

145. TIME OF BIRTH

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148. DATE OF BIRTH

149. TIME OF BIRTH

150. SIGNATURE

151. PLACE OF BIRTH

152. DATE OF BIRTH

153. TIME OF BIRTH

154. SIGNATURE

155. PLACE OF BIRTH

156. DATE OF BIRTH

157. TIME OF BIRTH

158. SIGNATURE

159. PLACE OF BIRTH

160. DATE OF BIRTH

161. TIME OF BIRTH

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163. PLACE OF BIRTH

164. DATE OF BIRTH

165. TIME OF BIRTH

166. SIGNATURE

167. PLACE OF BIRTH

168. DATE OF BIRTH

169. TIME OF BIRTH

170. SIGNATURE

171. PLACE OF BIRTH

172. DATE OF BIRTH

173. TIME OF BIRTH

174. SIGNATURE

175. PLACE OF BIRTH

176. DATE OF BIRTH

177. TIME OF BIRTH

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199. PLACE OF BIRTH

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201. TIME OF BIRTH

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203. PLACE OF BIRTH

204. DATE OF BIRTH

205. TIME OF BIRTH

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207. PLACE OF BIRTH

208. DATE OF BIRTH

209. TIME OF BIRTH

210. SIGNATURE

211. PLACE OF BIRTH

212. DATE OF BIRTH

213. TIME OF BIRTH

214. SIGNATURE

215. PLACE OF BIRTH

216. DATE OF BIRTH

217. TIME OF BIRTH

218. SIGNATURE

219. PLACE OF BIRTH

220. DATE OF BIRTH

221. TIME OF BIRTH

222. SIGNATURE

223. PLACE OF BIRTH

224. DATE OF BIRTH

225. TIME OF BIRTH

226. SIGNATURE

227. PLACE OF BIRTH

228.

8

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		STATE MARYLAND		COUNTY Allegany			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CUMBERLAND		12 DAYS		TOWN ELLERSLIE			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
MEMORIAL HOSPITAL							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) HUGH (Middle) W (Last) BURKETT				(Month) JAN. (Day) 21 (Year) 19 56			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
MALE	WHITE	MARRIED	JULY 8, 1873	82 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Ret. Mach.		Celanese Corp		Choice PENNSYLVANIA		U. S. A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Jesse BURKETT				XGARDNER, Sarah Reisslings			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
NO		214-07-4329		MEMORIAL HOSPITAL			
				WARWICK & MEMORIALS AVES.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) Cerebro-vascular accident						2 wks	
ANTECEDENT CAUSE(S) DUE TO (B) Chronic Hypertensive Cardiac-Vascular disease						5 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 21 , 19 50 , to Jan 21 , 19 56 , that I last saw the deceased alive on Jan 21 , 19 56 , and that death occurred at 3:40 P.M. , from the causes and on the date stated above.							
SIGNATURE Walter L. Zupper				ADDRESS (Street, city, town, state)		DATE SIGNED 1-24-56	
M.D. Hyndman						(State)	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
Burial		Jan 25 1956		Porters Cemetery		Near Hyndman, Penn	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Jan 25, 1956		Walter L. Zupper, M.D.		John J. Hafer		Cumberland, Maryland	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX AND AGE

4. DATE OF DEATH

5. CAUSE OF DEATH

6. PLACE OF BIRTH

7. OCCUPATION

8. DURATION OF ILLNESS

9. MANNER OF DEATH

10. NAME OF PHYSICIAN

11. DATE OF BIRTH

12. SEX

13. AGE

14. RACE

15. COLOR

16. DATE OF DEATH

17. PLACE OF DEATH

18. CAUSE OF DEATH

19. PLACE OF BIRTH

20. OCCUPATION

21. DURATION OF ILLNESS

22. MANNER OF DEATH

23. NAME OF PHYSICIAN

BUREAU V. S.

JAN 28 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY	Allegany	STATE	Maryland
CITY (If outside corporate limits, write RURAL and give nearest town)	Cumberland	COUNTY	Allegany
TOWN		CITY (If outside corporate limits, write RURAL and give nearest town)	Lonaconing
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Allegany County Infirmary	STREET ADDRESS	8 Allegany Street

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
Ella	E.	Burns		January 19,	19	56	

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.
Female	White	Widow	9/15/1880	75 yrs.	Months	Days

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife &	Domestic	Lonaconing, Maryland	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Peter Nolan	Johanna Collins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No	None	Allegany County Infirmary Records

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
334X IMMEDIATE CAUSE (A)	Pulmonary Hypostasis		16 hrs		
ANTECEDENT CAUSE(S) DUE TO	Chronic myocarditis		?		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	borderal arteriosclerosis		?		
(C)	Senile psychosis		?		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 28, 1955, to Jan. 19, 1956, that I last saw the deceased alive on Jan. 19, 1956, and that death occurred at 4:30 P.M. from the causes and on the date stated above.	
SIGNATURE	DATE SIGNED
James E. McLean M.D.	1-20-56
ADDRESS (Street, city, town, state)	
49 Greene St.	

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan, 21, 1956	St. Marys Cemetery.	Lonaconing, MD.

24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
Jan. 21, 1956	Walter L. Frantz, M.D.	GEORGE EICHORN,	LONA CONING, MD

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

10013

HEALTH AND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

CERTIFICATE OF DEATH

Form No. 100-1

1. Name of deceased (Print or write full name)

James Earl Ray

2. Sex

Male

3. Date of birth

May 19, 1928

4. Place of birth

Albany, Georgia

5. Usual place of residence

6. Race

7. Color

8. Marital status

9. Education

10. Occupation

11. Cause of death (Print or write full name of disease or injury)

12. Immediate cause of death

13. Duration of illness or injury

14. Place of death

15. Name and address of physician (Print or write full name and address)

16. Name and address of funeral home (Print or write full name and address)

BUREAU V. S.

JAN 24 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00014

Within corporate limits

10

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		MARYLAND		STATE Maryland		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Cumberland		12/28/50		TOWN National Highway, La Valle			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary				STREET ADDRESS LaValle - National Highway			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
Mary Amelia Carscaden				January 8, 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White	Widow	11/5/1862	93	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Own Home		Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Jacob Brengle				Sarah Boogher			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		None		Allegany County Infirmary Records			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
592X IMMEDIATE CAUSE (A)				Chronic Myocardial Degeneration		?	
ANTECEDENT CAUSE(S) DUE TO				Cerebral arteriosclerosis		?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO				Chronic Nephritis		?	
(C)				Senile Deterioration.		?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 2, 1952, to Jan 8, 1956, that I last saw the deceased alive on Jan 7, 1956, and that death occurred at 4:10 P.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
James E. McLeavey M.D.				49 Greene St.		1-9-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		1-11-56		Rose Hill Cemetery		Cumberland, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 1-11-56		W. R. Gravely, M.D.		Charles L. George		Cumberland, Md.	

CERTIFICATE OF DEATH

For Use of

1. Name of Deceased: **Alfred**

2. Date of Death: **12/28/50**

3. Place of Death: **National Highway, La Valle**

4. Date of Birth: **January 8, 1882**

5. Place of Birth: **Washington**

6. Sex: **Male**

7. Age: **68**

8. Occupation: **Widow**

9. Cause of Death: **Heart Disease**

10. Signature of Physician: **W. H. H. H.**

11. Signature of Registrar: **W. H. H. H.**

12. Signature of Coroner: **W. H. H. H.**

13. Signature of Medical Examiner: **W. H. H. H.**

14. Name of Hospital: **St. Mary's Hospital**

BUREAU A. 2

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00015

No. 6

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>W. Va.</u>		COUNTY <u>Mineral</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Westernport</u>		<u>6 days</u>		TOWN <u>Piedmont</u>		<u>85 X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Small creek Pt. 36</u>				STREET ADDRESS (If rural, give location) <u>49 W Harrison St</u> ✓			
3. NAME OF DECEASED:		(First) <u>Joseph</u>		(Middle) <u>Cirillo</u>		(Last) <u>Cirillo</u>	
(Type or Print)				4. DATE OF DEATH		5. AGE last birthday:	
				<u>Jan. 18</u>		<u>19 56</u>	
6. SEX:	7. COLOR OR RACE:	8. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	9. DATE OF BIRTH:	10. AGE last birthday:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Jan 12 1870</u>	<u>86</u> yrs.	<u>Nicola, Italy</u>	<u>Italy</u>	<u>No.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Laborer</u>		<u>City of Luke</u>		<u>Nicola, Italy</u>		<u>Italy</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>James Cirillo</u>				<u>Do not know</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
(If Yes, give war or dates of service)				<u>Catherine Cirillo, Piedmont, W. Va.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
<p>9328</p> <p>Immediate cause (a) <u>Exposure</u></p> <p>DUE TO</p> <p>Antecedent cause(s) (b)</p> <p>Diseases or conditions, if any, giving rise to the above cause DUE TO</p> <p>stating underlying cause last (c)</p>		<u>6 days</u>

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
<u>Severely feeble minded</u>	

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <u>While at work</u>	21c. (City or town) (County) (State)
		<u>Westernport, Allegany, Md</u>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Jan. 18/56 PM.</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. INJURY OCCURRED <u>Wandered away from home, fell down embankment to Creek, froze to death</u>

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE	CHIEF MEDICAL EXAMINER	DEPUTY MEDICAL EXAMINER	ASSISTANT MEDICAL EXAM.	DATE SIGNED
<u>H. V. Deming, M.D.</u>	<u>H. V. Deming, M.D.</u>			<u>Jan 24, 1956</u>

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Buried</u>	<u>Jan 26 56</u>	<u>St. Peter's Cemetery</u>	<u>Westernport, Md</u>	

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>Jan 25, 1956</u>	<u>John C Kelly</u>	<u>Harold Fudlocky</u>	<u>Piedmont W. Va.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 8

JAN 26 1956

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

72

00016
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 9

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Frostburg</u>		<u>5 days</u>		TOWN <u>Corrigansville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u>				STREET ADDRESS (If rural, give location) <u>R.F.D.#1 Hyndman, Pa.</u>			
3. NAME OF DECEASED: (First) <u>Edward</u>		(Middle) <u>Andrew</u>		(Last) <u>Clarkson</u>		4. DATE OF DEATH (Month) <u>Jan.</u> (Day) <u>8</u> (Year) <u>19 56</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>	8. DATE OF BIRTH: <u>June 27-1931</u>	9. AGE last birthday: <u>24</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Shut down Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Yarn & Martin, Baltimore, Md.</u>		11. BIRTHPLACE (State or foreign country): <u>Corrigansville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>James Clarkson</u>				14. MOTHER'S MAIDEN NAME: <u>Loretta Robinette</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY No.: <u>W.W.H. 217-28-7521</u>		17. INFORMANT & ADDRESS: <u>Miner Hospital records.</u>			

18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						<u>5 days</u>	
<u>816X</u>		(a) <u>Peritonitis</u>					
Immediate cause		DUE TO					
Antecedent cause(s)		(b) <u>Ruptured bowel and bladder.</u>					
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		DUE TO					
		(c) <u>Auto accident.</u>					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg, etc.) <u>Stingray Depot Hill</u>		21c. (City or town) <u>Frostburg</u> (County) <u>Allegany</u> (State) <u>Md.</u>			
21d. TIME (Month) (Day) (Year) <u>Jan. 3/56</u> OF INJURY <u>A.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Probable operator under influence, hit another car.</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED	
<u>H.V. Deming M.D.</u>		<u>H.V. Deming M.D.</u>		<u>M.D.</u>		<u>Jan. 8-1956</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>Jan. 10, 1956</u>		NAME OF CEMETERY OR CREMATORY: <u>Palo Alto Cemetery</u>		LOCATION (City, town or county) (State): <u>Palo Alto, Pennsylvania</u>	
DATE REC'D BY LOCAL REG. <u>Jan. 9, 1956</u>		REGISTRAR'S SIGNATURE: <u>Mrs. Nancy N. Roe</u>		24. FUNERAL DIRECTOR: <u>Louis Stein, Inc., Cumberland, Md.</u>			

RECEIVED

JAN 11 1956

BUREAU V. S.

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. Public Health Corporation Limited

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00017

11

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>7 Days</u>		TOWN <u>Mt. Savage</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u>				STREET ADDRESS (If rural give location) <u>Columbia Ave.,</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>George</u> (Middle) <u>Thomas</u> (Last) <u>Coleman</u>				<u>Jan.</u> <u>15.</u> <u>1956.</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 21, 1892</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours
							Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Roll operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Kelly Tire Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Gilmore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin Coleman</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Poland</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes, W. W. # 1</u>				16. SOCIAL SECURITY NO. <u>215-10-1521</u>		17. INFORMANT & ADDRESS <u>Mrs. Beatrice Coleman Mt. Savage, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
541.1 IMMEDIATE CAUSE (A) <u>Perforated duodenal ulcer</u>						<u>2 weeks</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes mellitus, coronary heart disease</u>						<u>6 years</u>	
19a. DATE OF OPERATION <u>1-9-56</u>		19b. MAJOR FINDINGS OF OPERATION <u>Perforated ulcer. Hydroco of Sacc bladder</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-8</u> , 19 <u>56</u> , to <u>1-15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-15</u> , 19 <u>56</u> , and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Laura L. Baeris</u>				ADDRESS (Street, city, town, state) <u>M.D. 62 Greene Cumberland Md</u>			
DATE SIGNED <u>1-15-56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/18/56</u>		NAME OF CEMETERY OR CREMATORY <u>St. George Episcopal Cem.</u>		LOCATION (City, town, or county) (State) <u>Mount Savage, Md.</u>	
24. REC'D BY REGISTRAR <u>Jan 17, 1956</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. Wayne George</u>		ADDRESS <u>Cumberland, Maryland</u>	

CERTIFICATE OF DEATH

Birth Date: _____

1. Usual Residence Name of Deceased _____

2. Name of Deceased _____
 3. Sex _____
 4. Race _____
 5. Date of Birth _____
 6. Date of Death _____
 7. Place of Death _____
 8. Cause of Death _____
 9. Manner of Death _____
 10. Signature of Physician _____
 11. Signature of Registrar _____
 12. Date of Registration _____

13. Name of Informant _____
 14. Address of Informant _____
 15. Signature of Informant _____

16. Name of Informant _____
 17. Address of Informant _____
 18. Signature of Informant _____

19. Name of Informant _____
 20. Address of Informant _____
 21. Signature of Informant _____

22. Name of Informant _____
 23. Address of Informant _____
 24. Signature of Informant _____

25. Name of Informant _____
 26. Address of Informant _____
 27. Signature of Informant _____

28. Name of Informant _____
 29. Address of Informant _____
 30. Signature of Informant _____

31. Name of Informant _____
 32. Address of Informant _____
 33. Signature of Informant _____

BUREAU V. S.

JAN 18 1956

RECEIVED

INSTRUCTIONS

1. This form is to be filled out by the physician or other person who has attended the deceased or who has been in attendance at the death. It should be filled out as soon as possible after death and before the body is moved or buried. It should be filled out in the presence of the registrar or other official of the health department. It should be filled out in the presence of the informant. It should be filled out in the presence of the witnesses. It should be filled out in the presence of the family. It should be filled out in the presence of the community. It should be filled out in the presence of the world.

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CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegheny</u>		MARYLAND		STATE <u>Pennsylvania</u>		COUNTY <u>Bedford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Cumberland</u>		<u>10 hours</u>		TOWN <u>Hyndman</u>		<u>75X-8</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Memorial Hospital</u>							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<u>Jessie Rebecca Cook</u>				<u>Jan. 1, 1956</u> 19			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>Aug. 2, 1883</u>	<u>72</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Own Housework</u>		<u>Hyndman, Pa.</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Michael Jordan</u>				<u>Laura Valentine</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>David H. Cook, Hyndman, Pa.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
4437 IMMEDIATE CAUSE (A) <u>Constrictive Heart Failure</u>						<u>2 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Hypertensive Cordis - Vascular Disease</u>						<u>6 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 1, 1956</u> , to <u>Jan 1, 1956</u> , that I last saw the deceased alive on <u>Jan 1, 1956</u> , and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John A. Lopper</u> M.D.				ADDRESS (Street, city, town, state) <u>Hyndman Pa</u>			
				DATE SIGNED <u>1-2-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Jan. 6, 1956</u>		<u>Hyndman Cemetery</u>		<u>Hyndman, Pa.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Jan. 5, 1956</u>		<u>Walter R. Trantz, M.D.</u>		<u>Walter R. Trantz</u>		<u>Hyndman, Pa.</u>	

VS A15C 1-55 10M

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

2100

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

FILE NO.

LOCAL HEALTH OFFICE NO.

NAME

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

PREVIOUS ILLNESS

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

TIME OF DEATH

TEMPERATURE

PULSE

BLOOD PRESSURE

WEIGHT

HEIGHT

HAIR

EYES

TEETH

SKIN

HEENT

HEENT

HEENT

HEENT

HEENT

Chronic Hypertensive Heart - Brain
Myocardial Infarction

BUREAU V. S.

JAN 1 1961

REGISTER

FILE NO.

INSTRUCTIONS

1. This form is to be filled out by the attending physician or other qualified person who has attended the deceased.

2. The cause of death should be stated in plain language, and should be based on the findings of the attending physician or other qualified person.

3. The date and place of death should be stated.

4. The sex, age, race, and education of the deceased should be stated.

5. The occupation of the deceased should be stated.

6. The religion of the deceased should be stated.

7. The previous illness of the deceased should be stated.

8. The date of birth of the deceased should be stated.

9. The place of birth of the deceased should be stated.

10. The education of the deceased should be stated.

11. The occupation of the deceased should be stated.

12. The religion of the deceased should be stated.

13. The previous illness of the deceased should be stated.

14. The date of death of the deceased should be stated.

15. The place of death of the deceased should be stated.

16. The time of death of the deceased should be stated.

17. The temperature of the deceased should be stated.

18. The pulse of the deceased should be stated.

19. The blood pressure of the deceased should be stated.

20. The weight of the deceased should be stated.

21. The height of the deceased should be stated.

22. The hair of the deceased should be stated.

23. The eyes of the deceased should be stated.

24. The teeth of the deceased should be stated.

25. The skin of the deceased should be stated.

26. The HEENT of the deceased should be stated.

27. The HEENT of the deceased should be stated.

28. The HEENT of the deceased should be stated.

29. The HEENT of the deceased should be stated.

30. The HEENT of the deceased should be stated.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00019

73

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Frostburg</u>		<u>2 Hrs.</u>		TOWN <u>Frostburg,</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miner's Hospital</u>				STREET ADDRESS (If rural give location) <u>93 W. Main Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Sidney</u> (Middle) <u>H.</u> (Last) <u>Craze</u>				(Month) <u>Jan.</u> (Day) <u>28th</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>May 26th, 1882</u>	<u>73</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired Electrician</u>		<u>Pot. Edison Co.</u>		<u>England</u>		<u>USA</u>	
13. FATHER'S NAME <u>William Craze</u>				14. MOTHER'S MAIDEN NAME <u>Mary Bond</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)		<u>214-10-5068A</u>		<u>93 W. Main St., Mrs. Mary M. Beck, Frostburg, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Bronchio-pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>asthmatic bronchitis</u>						<u>8 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cardiac Hypertrophy</u>						<u>8 yrs.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6-1</u> , 19 <u>54</u> , to <u>1-28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-28</u> , 19 <u>56</u> , and that death occurred at <u>7:30</u> M., from the causes and on the date stated above.							
SIGNATURE <u>H.C. Diehl</u>				ADDRESS (Street, city, town, state)		DATE SIGNED <u>1/30/56</u>	
M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1-31-1956</u>		<u>Ft.bg. Memorial Park</u>		<u>Frostburg, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>1-31-56</u>		<u>Mrs. Nancy N. Rae</u>		<u>Joseph R. Durst, Frostburg, Md.</u>			

BUREAU V. S.

FEB 6 1955

RECEIVED

1

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00020

91 - CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		MARYLAND		STATE MD		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Lonaconing				TOWN Castle street		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Castle Street				STREET ADDRESS (If rural give location) Lonaconing, MD.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) CATHERINE (Middle) CREIGHTON (Last)				(Month) JAN. (Day) 19th. (Year) 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White	Widowed	Dec, 12th, 1875	80 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housework		Own Home		Nova Scotia		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
William McCann				Margaret Donaldson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		None		Ellen Creighton (Daughter)			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE (A)				Cerebral Hemorrhage		22 min	
ANTECEDENT CAUSE(S) DUE TO				Cerebral Arteriosclerosis		3 yr.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO				Generalized Atherosclerosis		3 4 yr.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July , 19 52 , to Jan 19 , 19 56 ; that I last saw the deceased alive on Jan 5 , 19 56 , and that death occurred at 7:10 P.M. , from the causes and on the date stated above.							
SIGNATURE George Richards M.D.				ADDRESS (Street, city, town, state) Lonaconing, Md.		DATE SIGNED 1/21/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Jan, 22, 1956		Memorial Park		Frostburg, MD.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 1-22-56		Jannette M. Boul		GEORGE EICHHORN, LONA CONING, MD.			

BUREAU V. S.

JAN 30 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

92

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00021

 Items 8,9: film G191
1-13-56 L

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY <u>Lonaconing</u>		LENGTH OF STAY (in this place) <u>75 yrs</u>		TOWN <u>Lonaconing</u>		TOWN <u>Lonaconing</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS (If rural give location) <u>Castle Hill</u>					
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>David Ingles Creighton</u>				<u>Jan 3 19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Nov 30, 1872 '74</u>	<u>81 88</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Mine</u>		11. BIRTHPLACE (State or foreign country) <u>Bellshill Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert G. Creighton</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Ingles</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-05-2910</u>		17. INFORMANT & ADDRESS <u>Ellen Creighton Lonaconing, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
<u>332</u> IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>				<u>Daughter</u>		<u>6-8 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral Arteriosclerosis</u>						<u>2 years.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>UNDERLYING CAUSE LAST.</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 1952</u> , to <u>3 Jan 1956</u> , that I last saw the deceased alive on <u>2 Jan 1956</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>George Richards</u> M.D. <u>51 Main St. Lonaconing, Md</u>				DATE SIGNED <u>1/3/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/5/56</u>		NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Januette M Boal</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George Eichhorn</u>		ADDRESS <u>Lonaconing, Md.</u>	
DATE <u>1-5-56</u>							

1891

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

CERTIFICATE OF DEATH

For Use by

1. Name of Deceased

2. Age

3. Sex

4. Race

5. Date of Death

6. Time of Death

7. Place of Death

8. Cause of Death

9. Manner of Death

10. Signature of Physician

11. Signature of Registrar

12. Signature of Coroner

13. Signature of Burial Officer

14. Name of Burial Place

15. Name of Burial Officer

16. Name of Burial Officer

17. Name of Burial Officer

18. Name of Burial Officer

19. Name of Burial Officer

20. Name of Burial Officer

21. Name of Burial Officer

22. Name of Burial Officer

23. Name of Burial Officer

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55. Name of Burial Officer

56. Name of Burial Officer

57. Name of Burial Officer

58. Name of Burial Officer

BUREAU V. S.

JAN 9 1901

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1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00022

74

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Frostburg,</u>		1 week		TOWN <u>Frostburg,</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Miner's Hospital</u>				<u>92 Hill Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Rachel H. Dando</u>				<u>Jan. 26th, 19 56</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>Female</u>		<u>White</u>		<u>Widowed</u>		<u>Nov. 2nd, 1868</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE last birthday		IF UNDER 1 YEAR IF UNDER 24 HRS.	
<u>Housewife</u>		<u>Housework</u>		<u>87 yrs.</u>		Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
<u>Maryland</u>				<u>USA</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>William Hamilton</u>				<u>Martha Koontz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)				<u>92 Hill St., Mrs. Lillian Hamilton, F'bg., Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
153X IMMEDIATE CAUSE (A) <u>Carcinoma of ascending Colon</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senility</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-26</u> , 19 <u>55</u> , to <u>1-26</u> , 19 <u>56</u> , that I last saw the deceased elive on <u>1-26</u> , 19 <u>56</u> , and that death occurred at <u>11:45 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>H. C. Diehl</u>		M.D.		ADDRESS (Street, city, town, state) <u>Frostburg, Md.</u>		DATE SIGNED <u>1/28/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-29-56</u>		NAME OF CEMETERY OR CREMATORY <u>F'bg. Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mrs. Nancy W. Rae</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Durst</u>		ADDRESS <u>Frostburg, Md.</u>	

CERTIFICATE OF DEATH

THESE THINGS

1. USUAL RESIDENCE (HOUSE OR APARTMENT)

2. PLACE OF BIRTH

THE DECEASED WAS

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF BURIAL

PLACE OF BURIAL

DATE OF CREMATION

PLACE OF CREMATION

DATE OF REINTERMENT

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BUREAU V. S.

FEB 1 1956

RECEIVED

INSTRUCTIONS

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>Cumberland</u>		LENGTH OF STAY (In this place) <u>50 Min.</u>		TOWN <u>(Rural) Cumberland.</u>		STREET ADDRESS (If rural give location) <u>Rt 3, Box 351</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u>							
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Baby Girl Davidson</u>				<u>1-5-56</u> <u>19</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>1-5-56</u>	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months	Days	Hours	Min.
							<u>50</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Charles Davidson</u>				14. MOTHER'S MAIDEN NAME <u>Laura Shaffer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Charles Davidson, Cumberland, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>761.5</u>				INTERVAL BETWEEN ONSET AND DEATH <u>50 minutes</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Immaturity of vital structures</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Premature rupture of amniotic Membrane</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5 Jan, 1956</u> , to <u>5 Jan, 1956</u> , that I last saw the deceased alive on <u>5 Jan, 1956</u> , and that death occurred at <u>8:45 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>Blond Cannon</u> M.D. <u>63 Greene St. Camb. Md.</u>				DATE SIGNED <u>At 6 Jan 56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>Jan 7 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Memorial Hospital</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR <u>Jan 7, 1956</u>		REGISTRAR'S SIGNATURE <u>Walter B. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter B. Frantz</u>		ADDRESS <u>Cumberland, Md.</u>	

VS A15C 1-55 10M

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

1
Without corporate limits

CERTIFICATE OF DEATH

Reg. Dist. No.

1. Usual Residence (Home or Hospital)

2. Date of Death

3. Cause of Death

4. Medical Certification

5. Signature of Physician

6. Signature of Registrar

7. Signature of Coroner

8. Signature of Medical Examiner

9. Signature of Health Officer

10. Signature of County Clerk

11. Signature of State Registrar

12. Signature of State Health Officer

13. Signature of State Health Officer

14. Signature of State Health Officer

15. Signature of State Health Officer

16. Signature of State Health Officer

17. Signature of State Health Officer

18. Signature of State Health Officer

19. Signature of State Health Officer

20. Signature of State Health Officer

21. Signature of State Health Officer

22. Signature of State Health Officer

23. Signature of State Health Officer

24. Signature of State Health Officer

BUREAU V. S.

AN 11 1956

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INSTRUCTIONS

1. This certificate is to be filled out by the physician or other qualified person who has attended the deceased during the last illness. It should be filled out as soon as possible after death, and should be signed by the physician or other qualified person who has attended the deceased during the last illness. It should be filed with the local health officer, who will forward it to the State Registrar of Health.

1
Within corporate limits

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

DR R J WMS.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00024

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE W VA.		COUNTY Mineral	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN CUMBERLAND		8 DAYS		TOWN PIEDMONT		858-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
MEMORIAL HOSPITAL				108 E HAMPSHIRE STREET			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
CHARLES L DAVIS				JAN. 17 19 56			
5. SEX	6. COLOR OR	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
MALE	WHITE	MARRIED	1873	82 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired supervisor-W. Va. Pulp & Paper Co.				PIEDMONT W. VA.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
JOHN C. DAVIS				ELIZABETH A. DAVIS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
No						Memorial Hospital	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A)				Cerebral Hemorrhage			
ANTECEDENT CAUSE(S) DUE TO (B)				Art Selb CVD.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)				Ravages of age			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1/9/56, 19....., to 1/17/56, 19....., that I last saw the deceased alive on 1/15/56, 19....., and that death occurred at 4:07 P.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
[Signature]				Cumberland		1/18/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
Burial				Philos Cemetery		Westernport, Maryland.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Jan. 20, 1956		[Signature]		Fredlock Funeral Home, Piedmont, W. Va.			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

U.S. 100-10

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

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BUREAU V. S.

AN 23 1956

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STATE DEPARTMENT OF HEALTH - BALTIMORE 18

U.S. 100-10

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00025

15

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>		LENGTH OF STAY (in this place) <u>54 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00 I29 Grand Ave.</u>				STREET ADDRESS (If rural give location) <u>I29 Grand Ave.</u>			
3. NAME OF DECEASED (Type or Print) <u>Minnie Lee Davis</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>I - 30 - 1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Dec. 28, 1866</u>	9. AGE last birthday <u>89</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clothes store</u>		11. BIRTHPLACE (State or foreign country) <u>Sperryville, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Silas Atkins</u>				14. MOTHER'S MAIDEN NAME <u>Mildred Cannon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Harry L. Davis Cumberland, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>422.1 Chronic Myocarditis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>				<u>10 yrs.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 1, 1955</u> , to <u>Jan 30, 1956</u> , that I last saw the deceased alive on <u>Jan 30, 1956</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Clayton S. Surratt</u> M.D.				ADDRESS (Street, city, town, state) <u>Cumberland</u>		DATE SIGNED <u>1/31/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2-1-56</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cem.</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR <u>Feb. 1, 1956</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli</u> ADDRESS <u>Cumberland, Md</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

Form 10-1-55

1. DECEASED'S NAME (Last, first, middle initial)

2. DECEASED'S SEX AND AGE (at death)
 SEX: ☐ Male ☐ Female
 AGE: ☐ Under 1 year ☐ 1 year to 4 years ☐ 5 years to 14 years ☐ 15 years to 24 years ☐ 25 years to 44 years ☐ 45 years to 64 years ☐ 65 years and over

3. DATE OF DEATH (Month, day, year)
 MONTH: ☐ Jan ☐ Feb ☐ Mar ☐ Apr ☐ May ☐ Jun ☐ Jul ☐ Aug ☐ Sep ☐ Oct ☐ Nov ☐ Dec
 DAY: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17 ☐ 18 ☐ 19 ☐ 20 ☐ 21 ☐ 22 ☐ 23 ☐ 24 ☐ 25 ☐ 26 ☐ 27 ☐ 28 ☐ 29 ☐ 30 ☐ 31
 YEAR: ☐ 1954 ☐ 1955 ☐ 1956 ☐ 1957 ☐ 1958 ☐ 1959 ☐ 1960

4. PLACE OF DEATH (City, town, village, or hamlet)
 CITY, TOWN, VILLAGE, OR HAMLET: _____

5. COUNTY (Name)
 COUNTY: _____

6. DECEASED'S RESIDENCE (City, town, village, or hamlet)
 CITY, TOWN, VILLAGE, OR HAMLET: _____

7. DECEASED'S OCCUPATION (Name)
 OCCUPATION: _____

8. DECEASED'S MARITAL STATUS (Name)
 MARITAL STATUS: _____

9. DECEASED'S CAUSE OF DEATH (Name)
 CAUSE OF DEATH: _____

10. DECEASED'S MANNER OF DEATH (Name)
 MANNER OF DEATH: _____

11. DECEASED'S PLACE OF BIRTH (City, town, village, or hamlet)
 CITY, TOWN, VILLAGE, OR HAMLET: _____

12. DECEASED'S DATE OF BIRTH (Month, day, year)
 MONTH: ☐ Jan ☐ Feb ☐ Mar ☐ Apr ☐ May ☐ Jun ☐ Jul ☐ Aug ☐ Sep ☐ Oct ☐ Nov ☐ Dec
 DAY: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17 ☐ 18 ☐ 19 ☐ 20 ☐ 21 ☐ 22 ☐ 23 ☐ 24 ☐ 25 ☐ 26 ☐ 27 ☐ 28 ☐ 29 ☐ 30 ☐ 31
 YEAR: ☐ 1954 ☐ 1955 ☐ 1956 ☐ 1957 ☐ 1958 ☐ 1959 ☐ 1960

13. DECEASED'S PLACE OF DEATH (City, town, village, or hamlet)
 CITY, TOWN, VILLAGE, OR HAMLET: _____

14. DECEASED'S DATE OF DEATH (Month, day, year)
 MONTH: ☐ Jan ☐ Feb ☐ Mar ☐ Apr ☐ May ☐ Jun ☐ Jul ☐ Aug ☐ Sep ☐ Oct ☐ Nov ☐ Dec
 DAY: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17 ☐ 18 ☐ 19 ☐ 20 ☐ 21 ☐ 22 ☐ 23 ☐ 24 ☐ 25 ☐ 26 ☐ 27 ☐ 28 ☐ 29 ☐ 30 ☐ 31
 YEAR: ☐ 1954 ☐ 1955 ☐ 1956 ☐ 1957 ☐ 1958 ☐ 1959 ☐ 1960

15. DECEASED'S PLACE OF BIRTH (City, town, village, or hamlet)
 CITY, TOWN, VILLAGE, OR HAMLET: _____

16. DECEASED'S DATE OF BIRTH (Month, day, year)
 MONTH: ☐ Jan ☐ Feb ☐ Mar ☐ Apr ☐ May ☐ Jun ☐ Jul ☐ Aug ☐ Sep ☐ Oct ☐ Nov ☐ Dec
 DAY: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17 ☐ 18 ☐ 19 ☐ 20 ☐ 21 ☐ 22 ☐ 23 ☐ 24 ☐ 25 ☐ 26 ☐ 27 ☐ 28 ☐ 29 ☐ 30 ☐ 31
 YEAR: ☐ 1954 ☐ 1955 ☐ 1956 ☐ 1957 ☐ 1958 ☐ 1959 ☐ 1960

17. DECEASED'S PLACE OF DEATH (City, town, village, or hamlet)
 CITY, TOWN, VILLAGE, OR HAMLET: _____

18. DECEASED'S DATE OF DEATH (Month, day, year)
 MONTH: ☐ Jan ☐ Feb ☐ Mar ☐ Apr ☐ May ☐ Jun ☐ Jul ☐ Aug ☐ Sep ☐ Oct ☐ Nov ☐ Dec
 DAY: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17 ☐ 18 ☐ 19 ☐ 20 ☐ 21 ☐ 22 ☐ 23 ☐ 24 ☐ 25 ☐ 26 ☐ 27 ☐ 28 ☐ 29 ☐ 30 ☐ 31
 YEAR: ☐ 1954 ☐ 1955 ☐ 1956 ☐ 1957 ☐ 1958 ☐ 1959 ☐ 1960

19. DECEASED'S PLACE OF BIRTH (City, town, village, or hamlet)
 CITY, TOWN, VILLAGE, OR HAMLET: _____

20. DECEASED'S DATE OF BIRTH (Month, day, year)
 MONTH: ☐ Jan ☐ Feb ☐ Mar ☐ Apr ☐ May ☐ Jun ☐ Jul ☐ Aug ☐ Sep ☐ Oct ☐ Nov ☐ Dec
 DAY: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17 ☐ 18 ☐ 19 ☐ 20 ☐ 21 ☐ 22 ☐ 23 ☐ 24 ☐ 25 ☐ 26 ☐ 27 ☐ 28 ☐ 29 ☐ 30 ☐ 31
 YEAR: ☐ 1954 ☐ 1955 ☐ 1956 ☐ 1957 ☐ 1958 ☐ 1959 ☐ 1960

BUREAU V. S.

FEB 6 1956

RECEIVED

NOTIFICATION

TO THE ATTORNEY GENERAL, BALTIMORE, MARYLAND

TO THE ATTORNEY GENERAL, BALTIMORE, MARYLAND

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TO THE ATTORNEY GENERAL, BALTIMORE, MARYLAND

16

CERTIFICATE OF DEATH

Reg. Dist. No. 000264

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		STATE MARYLAND		COUNTY ALLEGANY			
CITY (If outside corporate limits, write RURAL OR end give nearest town) CUMBERLAND		LENGTH OF STAY (in this place) 5 DAYS		CITY (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL				STREET ADDRESS 629 MARYLAND AVENUE			
3. NAME OF DECEASED (First) SUSIE (Middle) E. (Last) DAVIS				4. DATE OF DEATH (Month) JANUARY (Day) 24 (Year) 19 56			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH APRIL 3 1889	9. AGE last birthday 66 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if not HOUSEWIFE)		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME KEPLINGER, GEORGE H.				14. MOTHER'S MAIDEN NAME MARTIN, ELLEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS MEMORIAL HOSPITAL			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) Cerebral vascular accident				INTERVAL BETWEEN ONSET AND DEATH 1 week			
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Arteriosclerosis and hypertensive heart disease				5 years			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12-3, 19 53, to 1-24, 19 56, that I last saw the deceased alive on 1-24, 19 56, and that death occurred at 1:25 A.M. from the causes and on the date stated above.							
SIGNATURE <i>Rosa G. Baccin</i>				DATE SIGNED <i>M.D. 62 June 9 Cumberland Md 1-24-56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Jan. 27, 1956		NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery		LOCATION (City, town, or county) (State) Cumberland, Md.	
24. REC'D BY REGISTRAR <i>Jan. 25, 1956</i>		REGISTRAR'S SIGNATURE <i>Walter R. Lang, M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>William H. Kight, Cumberland, Md.</i>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

CERTIFICATE OF DEATH

DECEASED

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

SEX

RESIDENCE

HOSPITAL

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

SEX

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

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CERTIFICATE OF DEATH

Reg. Dist. No. 4

17

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE ARTHUR		COUNTY GRANT	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CUMBERLAND,		1 DAY		TOWN WEST VIRGINIA		85X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) CLAUDE R		(Middle) R.		(Last) DAY		(Month) JAN. 30	
(Year) 19						56	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
MALE	WHITE	SINGLE	FEB. 2, 1885	70 yrs.	Months	Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Retired Farmer		Own Farm		W. VA.		U. S. A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
JOHN W. DAY				MARY S. HEAVNER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No				MEMORIAL HOSPITAL MEMORIAL AND WARWICK AVES			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
201X IMMEDIATE CAUSE (A)				Hodgkins Disease		One yr.	
ANTECEDENT CAUSE(S) DUE TO				Cardiovascular renal			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				Disease (Uremia)			
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1:29, 1956, to 1:30, 1956, that I last saw the deceased alive on 1:30, 1956, and that death occurred at 5:07 P.M. from the causes and on the date stated above.							
SIGNATURE W. J. Williams M.D.				ADDRESS (Street, city, town, state) Cumberland Md		DATE SIGNED 1-31-56	
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
Buried	Feb. 2, 1956	Maple Hill Cemetery		Petersburg		W. Va.	
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS			
Feb 1, 1956	Winter L. Frantz, M.D.	J. Blaine Schaffer		Petersburg, W. Va.			

INSTRUCTIONS

1 Within corporate limits

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

REG. NO. 100

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

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RACE

EDUCATION

OCCUPATION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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EDUCATION

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DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

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CAUSE OF DEATH

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DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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DATE OF BIRTH

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CAUSE OF DEATH

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PLACE OF MARRIAGE

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CAUSE OF DEATH

AGE

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DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

INSTRUCTIONS

1. This certificate is to be filled out by the attending physician or the coroner in the case of a sudden death. It should be filled out as soon as possible after death and should be signed by the physician or coroner. It should be filed in the office of the Registrar of the State Department of Health. It should be kept for a period of ten years. It should be made available to the public upon request. It should be made available to the courts upon request. It should be made available to the family upon request. It should be made available to the insurance company upon request. It should be made available to the employer upon request. It should be made available to the school upon request. It should be made available to the church upon request. It should be made available to the community upon request. It should be made available to the world upon request.

RECEIVED

FEB 6 1954

BUREAU V. S.

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INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

93

CERTIFICATE OF DEATH

00028

Reg. Dist. No. 8

| | | | | | | | |
|--|-------------------------|---|-------------------------|---|------------------------|---|-------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | STATE <u>Maryland</u> COUNTY <u>Allegany</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) | | TOWN | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | TOWN | |
| TOWN <u>Lonaconing</u> | | | | STREET ADDRESS | | (If rural give location) | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | <u>High Street</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <u>Terance</u> | | (Middle) <u>J.</u> | | (Last) <u>Devlin</u> | | (Date) <u>January 16</u> 19 <u>56</u> | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <u>Male</u> | <u>White</u> | <u>Widowed</u> | <u>Nov 22, 1875</u> | <u>80</u> yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>Retired Miner</u> | | <u>Coal Mine</u> | | <u>Lonaconing, Maryland</u> | | <u>U.S.A.</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>Henry Devlin</u> | | | | <u>Annie Woods</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| <u>no</u> | | <u>216-05-5859</u> | | <u>William Devlin Lonaconing, Md.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| <u>523.3</u> IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u> | | | | <u>"Son"</u> | | <u>3 min</u> | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | <u>3-4 years</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE | | | | <u>for Pulmonary</u> | | <u>10-15 yrs.</u> | |
| STATING UNDERLYING CAUSE LAST. DUE TO | | | | <u>Pneumonia</u> | | <u>2 mrs pres.</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | <u>Supra pubic prostatectomy</u> | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| <u>Nov 55</u> | | <u>Benign Prostatic Hypertrophy</u> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg, etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) | | (County) (State) | |
| <input type="checkbox"/> | | | | <u>Lonaconing, Md.</u> | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>July</u>, 19<u>52</u>, to <u>16 Jan</u>, 19<u>56</u>, that I last saw the deceased alive on <u>16 Jan</u>, 19<u>56</u>, and that death occurred at <u>6:12 P</u>.M, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | | | ADDRESS (Street, city, town, state) | | DATE SIGNED | |
| <u>George Richards</u> | | | | <u>Lonaconing, Md.</u> | | <u>1/17/56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>Jan 19, 1956</u> | | <u>St Marys</u> | | <u>Lonaconing, Md.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| <u>1-19-56</u> | | <u>Jeanette M. Boal</u> | | <u>George EICHORN</u> | | <u>Lonaconing, Md.</u> | |

(Faint, illegible text from bleed-through)

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00029

CERTIFICATE OF DEATH

Reg. Dist. No. 8

| | | | | | | | |
|---|-------------------------|--|--|--|--|---|---|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | STATE <u>MD.</u> COUNTY <u>Allegany</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) | | CITY (If outside corporate limits, write RURAL and give nearest town) | |
| CITY OR TOWN <u>Lonaconing</u> | | LENGTH OF STAY (in this place) | | CITY OR TOWN <u>Lonaconing</u> | | CITY OR TOWN <u>Lonaconing</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rockville Street</u> | | | | STREET ADDRESS (If rural give location) <u>Rockville Street</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| (First) <u>HENRIETTA</u> | | (Middle) <u>GREY</u> | | (Last) <u>DONALDSON</u> | | <u>Jan, 18th, 1956</u> | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <u>Female</u> | <u>White</u> | <u>Widowed</u> | <u>Dec, 2nd, 1863</u> | <u>95</u> yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Glasgow, Scotland.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>James Cuthbertson</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Christina Campbell</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT & ADDRESS <u>Miss. Jessie Donaldson, (Daughter)</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION <u>Lonaconing, MD.</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| <u>332X</u> IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u> | | | | | | <u>18 hr.</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral Arteriosclerosis</u> | | | | | | <u>5 yr.</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Generalized Arteriosclerosis</u> | | | | | | <u>10 yr.</u> | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>July 18, 1952</u> , to <u>Jan 18, 1956</u> , that I last saw the deceased alive on <u>Jan 18, 1956</u> , and that death occurred at <u>8:00 AM</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>George E. Richardson</u> | | M. D. <u>Lonaconing, Md</u> | | DATE SIGNED <u>1/19/56</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | DATE THEREOF <u>Jan, 20, 1956</u> | | NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u> | | LOCATION (City, town, or county) (State) <u>Frostburg, MD.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE <u>Jannette M. Boal</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>GEORGE EICHHORN?</u> | | ADDRESS <u>Lonaconing, MD.</u> | |
| DATE <u>1-20-56</u> | | | | | | | |

10089

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

CERTIFICATE OF DEATH

FILE NO.

1. USUAL RESIDENCE HOME OR DECEDENT

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF BURIAL

10. SIGNATURE

11. SIGNATURE

12. SIGNATURE

13. SIGNATURE

14. SIGNATURE

15. SIGNATURE

16. SIGNATURE

17. SIGNATURE

18. SIGNATURE

19. SIGNATURE

20. SIGNATURE

21. SIGNATURE

22. SIGNATURE

23. SIGNATURE

24. SIGNATURE

25. SIGNATURE

26. SIGNATURE

27. SIGNATURE

28. SIGNATURE

29. SIGNATURE

30. SIGNATURE

31. SIGNATURE

32. SIGNATURE

33. SIGNATURE

34. SIGNATURE

35. SIGNATURE

BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00030

Within corporate limits

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|---|----------------------------------|--|--|---|--|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Allegany</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN <u>Cumberland</u> | | LENGTH OF STAY
(In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN <u>Cumberland</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS
<u>539 Henderson Avenue</u> | | | | STREET ADDRESS
(If rural give location)
<u>539 Henderson Avenue</u> | | | |
| 3. NAME OF DECEASED
(Type or Print) <u>ROY FREDERICK DRUMM</u> | | | | 4. DATE OF DEATH
(Month) <u>January</u> (Day) <u>8</u> (Year) <u>1956</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
<u>Married</u> | 8. DATE OF BIRTH
<u>June 24, 1898</u> | 9. AGE last birthday
<u>57</u> yrs. | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Inspector</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Alleg. Co. Md.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Vale Summit, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Alcoholic Bev.</u>
<u>JOHN DRUMM</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>PRISCILLA KNIPPENBURG</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>317-10-4735</u> | | 17. INFORMANT & ADDRESS
<u>539 Henderson Ave.</u>
<u>Mrs. Nellie Drumm, Cumberland, Md.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 177X IMMEDIATE CAUSE (A) <u>Uremia</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>4 days</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) <u>Cancer of prostate</u> | | | | | | <u>1 1/2 years</u> | |
| STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> el work <input type="checkbox"/> Not white <input type="checkbox"/> el work <input type="checkbox"/> | | 21e. INJURY OCCURRED | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>6-3-</u> 19 <u>54</u> , to <u>1-8-</u> 19 <u>56</u> , that I last saw the deceased alive on <u>1-7-</u> 19 <u>56</u> , and that death occurred at <u>11A</u> M, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>L. Harris</u> | | | | ADDRESS (Street, city, town, state)
<u>576 Green St. Cumberland Md</u> | | DATE SIGNED
<u>1-10-56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | | DATE THEREOF
<u>Jan. 11, 1956</u> | | NAME OF CEMETERY OR CREMATORY
<u>Sts. Peters & Pauls Cem. Cumberland, Maryland</u> | | LOCATION (City, town, or county) (State) | |
| 24. REC'D BY REGISTRAR
DATE <u>1/11/56</u> | | REGISTRAR'S SIGNATURE
<u>W.R. Frantz, Jr. M.D.</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE
<u>John J. Hafer,</u> | | ADDRESS
<u>Cumberland, Maryland</u> | |

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19

CERTIFICATE OF DEATH

Reg. Dist. No. 4

Item 8, Film G192 2-7-56 et

| | | | | | | | |
|---|--------------------|--|--------------------------------------|--|-----------------|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY ALLEGANY | | MARYLAND | | STATE MARYLAND | | COUNTY ALLEGANY | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN CUMBERLAND | | 50 yrs. | | TOWN CUMBERLAND | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS 626 N. MECHANIC STREET | | | | STREET ADDRESS (If rural give location) 626 N. MECHANIC STREET | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) LULA | | (Middle) M. | | (Last) EHRBAR | | (Month) JAN. 26 19 56 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) DIVORCED | 8. DATE OF BIRTH 1897 SEPT. 27, 1898 | 9. AGE last birthday 58 yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME | | 11. BIRTHPLACE (State or foreign country) HAGERSTOWN, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME AGUSTINE NIERMAN | | | | 14. MOTHER'S MAIDEN NAME DAISY BELLE FREY | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT & ADDRESS MISS DOROTHY EHRBAR, SAME | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 2 years | |
| 422a. IMMEDIATE CAUSE (A) Chronic Myocarditis & Myocardial degeneration | | | | | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO | | | | | | | |
| STATING UNDERLYING CAUSE LAST. (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | | 21a. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from Feb 16th, 1955, to Jan 26th, 1956, that I last saw the deceased alive on Jan 19th, 1956, and that death occurred at 2:00A, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE R. H. Treweek, Jr. | | | | ADDRESS (Street, city, town, state) Cumberland, Maryland | | DATE SIGNED 1/27/56 | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | DATE THEREOF 1/28/56 | | NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY | | LOCATION (City, town, or county) CUMBERLAND, MD. | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE John R. Frantz, M.D. | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS JOHN J. HAFFER, CUMBERLAND, MD. | | | |

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

20

CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After the death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of the death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

| | | | | | | | |
|---|------------------|--|-----------------------|---|-----------------|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY ALLEGANY | | STATE MARYLAND | | COUNTY ALLEGANY | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN CUMBERLAND | | 3 DAYS | | TOWN FROSTBURG | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL | | | | STREET ADDRESS (If rural give location) APT. 1, CORNER 96 ARMOUR & CHESTNUT ST | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| CORA FATKIN | | | | JANUARY 20, 1956 | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| FEMALE | WHITE | MARRIED | APRIL 12, 1885 | 70 yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Housewife | | Own Home | | MARYLAND | | U. S. A. | |
| 13. FATHER'S NAME JOHN STEWART | | | | 14. MOTHER'S MAIDEN NAME ANNA M. PENGILLY | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| No | | None | | MEMORIAL HOSPITAL WARWICK & MEMORIAL AVE. | | | |
| 18. MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE (A) 1442X India vasculowrenal disease | | | | | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE | | | | | | | |
| STATING UNDERLYING CAUSE LAST, DUE TO | | | | | | | |
| (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from 1-17-56 , 19 56 , to 1-20-56 , 19 56 , that I last saw the deceased alive on 1-20-56 , 19 56 , and that death occurred at 4:30 P. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE M. J. Williams | | | | ADDRESS (Street, city, town, state) Cumberland Md | | | |
| DATE SIGNED 1-21-56 | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| Burial | | Jan. 23, 1956 | | Eckhart Cemetery | | Eckhart, Maryland. | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| Jan. 23, 1956 | | Walter R. Frantz, M.D. | | Durst Funeral Home, Frostburg, Maryland. | | | |

CERTIFICATE OF DEATH

ANNEXED STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

NAME: ALBERT J. ALBERTY
 SEX: MALE
 AGE: 65 YEARS
 DATE OF BIRTH: JANUARY 2, 1890
 PLACE OF BIRTH: BALTIMORE, MD

DECEASED AT: BALTIMORE, MD
 DATE OF DEATH: JANUARY 2, 1956
 PLACE OF DEATH: HOME

CAUSE OF DEATH: HEART DISEASE
 ICD-9 CODE: 410.9
 MEDICAL ATTENDING: DR. J. H. ALBERTY

PLACE OF DEATH: HOME
 SIGNATURE: J. H. ALBERTY
 TITLE: M.D.

PLACE OF DEATH: HOME
 SIGNATURE: J. H. ALBERTY
 TITLE: M.D.

BUREAU V. S.

JAN 24 1956

RECEIVED

NOTICE: This certificate is to be filled out by the attending physician or other qualified person. It is to be signed by the physician or other qualified person. It is to be filed in the office of the health officer. It is to be filed in the office of the health officer.

21 CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|---|-------------------|--|-------------------|---|-----------------------------|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Maryland</u> COUNTY <u>Allegany</u> | | | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN | | | |
| TOWN <u>Cumberland</u> | | 60 yrs. | | Cumberland | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| 195 Maryland Ave. | | | | 195 Maryland Ave. | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | | | 4. DATE (Month) (Day) (Year) OF DEATH: Jan. 21, 19 56 | | | |
| Maude Berttell Faulkner | | | | | | | |
| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: | 9. AGE last birthday | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. | |
| Female | White | Married | 10-8-1895 | 60 yrs. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): | | | | 10B. KIND OF BUSINESS OR INDUSTRY: | | 11. BIRTHPLACE (State or foreign country): | |
| Housewife | | | | Own home | | Cumberland, Md. | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | 13. FATHER'S NAME: | | | |
| U.S. | | | | William A. Twigg | | | |
| 14. MOTHER'S MAIDEN NAME: | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | | |
| Sallie Black | | | | No | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT & ADDRESS: | | | |
| None | | | | John C. Faulkner Cumberland, Md. | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 260X | |
| IMMEDIATE CAUSE | | | | | | 2 | |
| ANTECEDENT CAUSE (S) | | | | | | 80 YR. | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | | | | 80 YR. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | Chronic | |
| 19A. DATE OF OPERATION: | | | | | | 19B. MAJOR FINDINGS OF OPERATION | |
| none | | | | | | none | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) (County) (State) | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | none | | | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| none | | | | | | | |
| 22. I hereby certify that I attended the deceased from Jan. 21, 1956, to Jan. 21, 1956, that I last saw the deceased alive on Jan. 21, 1956, and that death occurred at 4:10 P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | ADDRESS | | DATE SIGNED | | | |
| J. H. Hallinan | | 140 Bedford St. Cumberland, Md. | | 1-22-1956 | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| Burial | | 1-23-1956 | | Cooks Mills Cem. | | Cooks Mills, Penna. | |
| DATE REC'D BY LOCAL REGISTRAR | | REGISTRAR'S SIGNATURE | | 24. FUNERAL DIRECTOR | | ADDRESS | |
| Jan. 23, 1956 | | Winter R. Brant, M.D. | | Charles L. George | | Cumberland, Md. | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATE DEPARTMENT OF HEALTH - BUREAU OF HEALTH

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RECEIVED JAN 24 1956 BUREAU V. S.

BUREAU V. S.

JAN 24 1956

RECEIVED

22

CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A155 1-55 10M

| | | | | | | | |
|--|---|---|--|--|---------------------------------------|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY ALLEGANY | | STATE MARYLAND | | COUNTY ALLEGANY | | | |
| CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | LENGTH OF STAY (In this place)
9 DAYS | | CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS
MEMORIAL HOSPITAL | | | | STREET ADDRESS (If rural give location)
#3 BROWNING | | | |
| 3. NAME OF DECEASED (First) GEORGE (Middle) W. (Last) FREELAND | | | | 4. DATE OF DEATH (Month) JAN. (Day) 22 (Year) 1956 | | | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
MARRIED | 8. DATE OF BIRTH
2-24, 1879 | 9. AGE last birthday
76 yrs. | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work)
Retired Chief Engineer & Air Inspector | | | | 10b. KIND OF BUSINESS OR INDUSTRY
RAILROADING B. & O. R. R. Co. | | 11. BIRTHPLACE (State or foreign country)
WEST VIRGINIA, Keyser | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | | | | | |
| 13. FATHER'S NAME
GEORGE FREELAND | | | | 14. MOTHER'S MAIDEN NAME
MARGARET SHAFFER | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
705-05-8561 | | 17. INFORMANT & ADDRESS
MEMORIAL HOSPITAL | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| IMMEDIATE CAUSE (A)
422.1 Cerebral Spasm | | | | | | INTERVAL BETWEEN ONSET AND DEATH
2 days | |
| ANTECEDENT CAUSE(S) DUE TO (B)
Arteriosclerotic Cardio Vascular Dis. | | | | | | 10 years | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. MAJOR FINDINGS OF OPERATION | | | |
| 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)
M. | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify, that I attended the deceased from 13 Jan., 1956, to 22 Jan., 1956, that I last saw the deceased alive on 22 Jan., 1956, and that death occurred at 11:20 P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE
<i>James L. Stegmann</i> | | | | DATE SIGNED
<i>12280 Centre St, Cumberland, Md. - 22 Jan 56</i> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | DATE THEREOF
Jan. 25, 1956 | | NAME OF CEMETERY OR CREMATORY
Trinity Lutheran Cemetery | | LOCATION (City, town, or county) (State)
Cumberland, Maryland | |
| 24. REC'D BY REGISTRAR
JAN. 24, 1956 | | REGISTRAR'S SIGNATURE
<i>Walter S. Brantz, M.D.</i> | | 25. FUNERAL DIRECTOR'S SIGNATURE
James F. Scarpelli, Cumberland, Maryland. | | | |

Y. 1. 1.

2Y.

100-5-212-2

2438

Charles E. ...

Intermittent Exotropia. Strab.

RECEIVED

JAN 25 1956

RECEIVED

1

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

00035

Reg. Dist. No. 4

Within corporate limits

23

| | | | | | | | |
|---|------------------|--|----------------------|--|-----------------|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Md.</u> | | COUNTY <u>Allegany</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Cumberland</u> | | <u>Lifetime</u> | | TOWN <u>Cumberland</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1009 Lexington Ave.</u> | | | | STREET ADDRESS (If rural give location) <u>1009 Lexington Ave.</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <u>Carl</u> (Middle) <u>Joseph</u> (Last) <u>Furstenberg</u> | | | | (Month) <u>1</u> (Day) <u>7</u> (Year) <u>1956</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <u>Male</u> | <u>White</u> | <u>married</u> | <u>Oct. 28, 1894</u> | <u>61</u> yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>Carman Helper</u> | | <u>Railroad</u> | | <u>Cumberland, Md.</u> | | <u>USA</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>John Furstenberg</u> | | | | <u>Margaret Stott</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| <u>no</u> | | <u>none</u> | | <u>John M. Furstenberg, Ridgeley, W. Va.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 4201 IMMEDIATE CAUSE (A) <u>Acute Coronary Occlusion - Thrombosis</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Myocarditis - Coronary Artery Disease</u> | | | | 6 months | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? | | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>55</u> , to <u>Jan</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/7</u> , 19 <u>56</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>J. J. Hunter</u> | | | | ADDRESS (Street, city, town, state) <u>133 Virginia Ave, Cumberland, Md.</u> | | DATE SIGNED <u>1/9/56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>1-10-56</u> | | <u>St. Mary's</u> | | <u>Cumberland, Md.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| DATE <u>1-10-56</u> | | <u>Walter R. Frantz, MD</u> | | <u>James F. Scarpelli</u> | | <u>Cumberland, Md.</u> | |

CERTIFICATE OF DEATH

FILE NO. 28

Date of Death

1. Name of Deceased

2. Sex

3. Age

4. Race

5. Birth Date

6. Birth Place

7. Date of Birth

8. Date of Death

9. Date of Burial

10. Date of Interment

11. Date of Cremation

12. Date of Disposition

13. Date of Return

14. Date of Reburial

15. Date of Reinterment

16. Date of Reburial

17. Date of Reinterment

18. Date of Reburial

19. Date of Reinterment

20. Date of Reburial

21. Date of Reinterment

22. Date of Reburial

23. Date of Reinterment

24. Date of Reburial

25. Date of Reinterment

26. Date of Reburial

27. Date of Reinterment

28. Date of Reburial

29. Date of Reinterment

30. Date of Reburial

31. Date of Reinterment

32. Date of Reburial

33. Date of Reinterment

34. Date of Reburial

35. Date of Reinterment

36. Date of Reburial

37. Date of Reinterment

38. Date of Reburial

39. Date of Reinterment

40. Date of Reburial

41. Date of Reinterment

42. Date of Reburial

43. Date of Reinterment

44. Date of Reburial

45. Date of Reinterment

BUREAU V. S.

JAN 12 1956

RECEIVED

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00036 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <u>Allegany</u> | MARYLAND | STATE <u>Md.</u> | COUNTY <u>Allegany</u> |
| CITY (If outside corporate limits, write RURAL and give nearest town)
OR <u>22 TOWN</u> <u>Cumberland</u> | LENGTH OF STAY (in this place)
<u>15 yrs.</u> | CITY (If outside corporate limits write RURAL and give nearest town)
OR <u>22 TOWN</u> <u>Cumberland</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>126 Bedford St.</u> | | STREET ADDRESS (If rural, give location)
<u>126 Bedford St.</u> | |
| 3. NAME OF DECEASED: | | 4. DATE OF DEATH | |
| (First) <u>Emma</u> | (Middle) <u>Virginia</u> | (Last) <u>Gable</u> | (Month) <u>Jan.</u> (Day) <u>16</u> (Year) <u>19 56</u> |
| 5. SEX: <u>female</u> | 6. COLOR OR RACE: <u>white</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widow</u> | 8. DATE OF BIRTH: <u>July 3-1870</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u> | 9. AGE last birthday: <u>85</u> yrs. |
| 11. BIRTHPLACE (State or foreign country): <u>Clearfield, Pa.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME: <u>William Kennedy</u> | | 14. MOTHER'S MAIDEN NAME: <u>Elvira Ray</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u> | | 16. SOCIAL SECURITY No.: <u>none</u> | |
| 17. INFORMANT & ADDRESS: <u>(son) Charles A. Gable, Cumberland, Md.</u> | | | |

| | | |
|--|--|--|
| 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | |
| <p>420.1</p> <p>Immediate cause (a) <u>Coronary sclerosis with occlusion</u></p> <p>DUE TO</p> <p>Antecedent cause(s) (b) <u>Generalized arteriosclerosis.</u></p> <p>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)</p> | | <p>sudden death.</p> <p>?</p> |
| 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | |
| 19a. DATE OF OPERATION: | 19b. MAJOR FINDING OF OPERATION: | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY) | 21c. (City or town) (County) (State) |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | |
| SIGNATURE | | |
| <u>H. V. Deming M.D.</u> <u>H. V. Deming M.D.</u>
CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Jan. 16-1956</u>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAM. <input type="checkbox"/> | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u> | DATE THEREOF: <u>Jan. 18, 1956</u> | NAME OF CEMETERY OR CREMATORY: <u>Shiloh Cemetery</u> |
| LOCATION (City, town, or county) (State): <u>Clearfield, Pennsylvania</u> | 24. FUNERAL DIRECTOR ADDRESS: <u>Louis Stein, Inc., Clearfield, Md.</u> | |
| DATE REC'D BY LOCAL REG. <u>Jan. 17, 1956</u> | REGISTRAR'S SIGNATURE: <u>Charles R. Frantz M.D.</u> | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 18 1956
BUREAU V. S.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18
Within corporate limits

00037

25

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|---|----------------------------------|--|--|---|--|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Maryland</u> COUNTY <u>Allegany</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN <u>Cumberland</u> | | LENGTH OF STAY (in this place)
<u>5 days</u> | | CITY (If outside corporate limits, write RURAL and give nearest town)
OR TOWN <u>Corriganville</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart</u> | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last)
<u>Samuel</u> <u>W.</u> <u>Garey</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year)
<u>Jan. 8, 1956</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
<u>Married</u> | 8. DATE OF BIRTH
<u>July 20, 1881</u> | 9. AGE last birthday
<u>74</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Carpenter and Farmer Farming</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Corriganville, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> |
| 13. FATHER'S NAME
<u>Samuel Garey</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Lucinda Hiner</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | | 17. INFORMANT & ADDRESS
<u>Mrs. Esther Lepley, Corriganville, Md.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 443X IMMEDIATE CAUSE (A) <u>Cerebral Vascular accident</u> | | | | | | <u>3 hrs.</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Hypertensive Cardiovascular disease</u> | | | | | | <u>5 yrs.</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Dec 1, 1955</u> to <u>Jan 8, 1956</u> , that I last saw the deceased alive on <u>Jan 8, 1956</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.
SIGNATURE <u>John A. Topper</u> M.D. ADDRESS <u>Hyndman, Pa.</u> DATE SIGNED <u>1-8-56</u> | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL, (SPECIFY)
<u>Burial</u> | | DATE THEREOF
<u>Jan. 12, 1956</u> | | NAME OF CEMETERY OR CREMATORY
<u>Hillcrest Cemetery</u> | | LOCATION (City, town, or county) (State)
<u>Cumberland, Md.</u> | |
| 24. REC'D BY REGISTRAR
DATE <u>1-12-56</u> | | REGISTRAR'S SIGNATURE
<u>W.R. Brantzy, M.D.</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
<u>Harvey H. Zeigler, Hyndman, Pa.</u> | | | |

ENCLOSURE

1
The undersigned, being a duly qualified medical practitioner, hereby certify that the above-named person died on the 22nd day of January, 1922, at the residence of the deceased, at the age of 22 years, of the disease of Chronic Hypertension of the Arteries, which was the result of an accident.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

00037

| | | | | | |
|----------------------------|--|----------------------------|--|--------------------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | |
| CHAS. H. HARRIS | | MALE | | 22 | |
| 4. PLACE OF BIRTH | | 5. OCCUPATION | | 6. CAUSE OF DEATH | |
| BALTIMORE, MD. | | LABORER | | CHRONIC HYPERTENSION OF THE ARTERIES | |
| 7. DATE OF DEATH | | 8. TIME OF DEATH | | 9. PLACE OF DEATH | |
| JAN 22 1922 | | 10:00 AM | | HOME | |
| 10. SIGNATURE OF PHYSICIAN | | 11. SIGNATURE OF WITNESSES | | 12. SIGNATURE OF DECEASED | |
| [Signature] | | [Signature] | | [Signature] | |

Chronic Hypertension of the Arteries
resulting from an accident

BUREAU V. S.

JAN 16 1922

RECEIVED

Attorney at Law

Jan 22 1922
[Signature]

26

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|---|---------------------------|--|---|---|--|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Allegany</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Cumberland</u> | | <u>7yrs. 4mo.</u> | | TOWN <u>Cumberland</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sylvan Retreat</u> | | | | STREET ADDRESS (If rural give location) <u>215 Cumberland Street</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <u>Beatrice</u> (Middle) <u>Agnes</u> (Last) <u>Getty</u> | | | | (Month) <u>January</u> (Day) <u>31</u> (Year) <u>1956</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S</u> | 8. DATE OF BIRTH <u>March 20, 1874</u> | | 9. AGE last birthday <u>81</u> yrs. | 10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Westernport, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>John Carr Getty</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Catherine Koontz</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT & ADDRESS <u>Hubert Farrell, Cumberland, Md (Nephew)</u> | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| IMMEDIATE CAUSE (A) <u>Pulmonary Hypostasis</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs.</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Myocarditis</u> | | | | | | <u>?</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Cerebral Arteriosclerosis</u> | | | | | | <u>?</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Simple psychosis</u> | | | | | | <u>7 yrs</u> | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Jan. 2, 1952</u> , to <u>Jan. 30, 1956</u> , that I last saw the deceased alive on <u>Jan. 30, 1956</u> , and that death occurred at <u>4:45 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>James B. Hean</u> | | | | M.D. <u>49 Green St.</u> | | DATE SIGNED <u>1-31-56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>Feb. 2, 1956</u> | | NAME OF CEMETERY OR CREMATORY <u>St. Peter's Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Westernport, Maryland</u> | |
| 24. REC'D BY REGISTRAR <u>Feb. 1, 1956</u> | | REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>E. S. Boal</u> | | ADDRESS <u>Westernport, Maryland.</u> | |

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

NOTIFICATION

THIS IS TO CERTIFY THAT THE FOLLOWING PERSON HAS BEEN NOTIFIED OF THE DEATH OF THE PERSON NAMED IN THE CERTIFICATE OF DEATH, AND THAT THE PERSON HAS BEEN ADVISED OF THE PLACE WHERE THE BODY OF THE DECEASED PERSON IS BEING KEPT, AND OF THE TIME AND PLACE WHERE THE FUNERAL WILL BE HELD.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BOSTON

Reg. No. 10

LOCAL RESIDENCE OF DECEASED

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

REASON FOR ENTRY

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

REASON FOR ENTRY

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

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OCCUPATION

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PLACE OF ENTRY

REASON FOR ENTRY

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TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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PLACE OF ENTRY

REASON FOR ENTRY

BUREAU V. S.

FEB 6 1952

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1

INSTRUCTIONS

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00039

75

CERTIFICATE OF DEATH

Reg. Dist. No. 9

| | | | | | | | |
|---|-------------------------|---|-------------------------|---|------------------------|---|-------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | STATE <u>Maryland</u> | | COUNTY <u>Allegany</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Frostburg</u> | | <u>2 days</u> | | TOWN <u>Frostburg</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| <u>61 Miner's Hospital</u> | | | | <u>172 Ormond Street</u> | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| <u>Ethel Griffith</u> | | | | <u>Jan. 3, 1956</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <u>Female</u> | <u>White</u> | <u>Single</u> | <u>Feb. 19th, 1899</u> | <u>56 yrs.</u> | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>Housework</u> | | <u>Housework -home own</u> | | <u>Maryland</u> | | <u>USA</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>William Griffith</u> | | | | <u>Catherine Hartig</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| (If Yes, give war or dates of service) | | <u>215 - 20 - 7311</u> | | <u>Mrs. Olive Duncan, Bowery St., F'bg. Md.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 174 X | | | | | | | |
| IMMEDIATE CAUSE (A) | | | | | | <u>2 Wks.</u> | |
| <u>Pulmonary Metastases</u> | | | | | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) | | | | | | <u>6 Months</u> | |
| <u>Adeno Carcinoma of uterus, anaplastic</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? | |
| <u>11/3/55</u> | | <u>Carcinoma uterus</u> | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>10/28, 1955</u>, to <u>1/3/56</u>, that I last saw the deceased alive on <u>1/3/56</u>, and that death occurred at <u>10:35 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | | | ADDRESS (Street, city, town, state) | | | |
| <u>Hilda Jankalakis</u> | | | | <u>48 Broadway, Frostburg, Md.</u> | | | |
| M.D. | | | | DATE SIGNED | | | |
| <u>Jan. 6th, 56</u> | | | | <u>1/4/56</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, of county) (State) | |
| <u>Burial</u> | | <u>Jan. 6th, 56</u> | | <u>F'bg. Memorial Park</u> | | <u>Frostburg, Md.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| <u>1-6-56</u> | | <u>Mr. Nancy H. Rose</u> | | <u>Joseph R. Durst, Frostburg, Md.</u> | | | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12 - 000123

Reg. Dist. No.

1. USUAL RESIDENCE (Place of Birth)

2. SEX

3. AGE

4. OCCUPATION

5. DATE OF DEATH

6. PLACE OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF DEATH CERTIFICATE

13. SIGNATURE OF DEATH CERTIFICATE

14. SIGNATURE OF DEATH CERTIFICATE

15. SIGNATURE OF DEATH CERTIFICATE

16. SIGNATURE OF DEATH CERTIFICATE

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THE JOURNAL OF

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

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VS AISC 1-55 10M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00040

27

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|---|---------------------------|--|--|---|-----------------|---|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Allegany</u> | |
| CITY OR TOWN <u>Cumberland</u> | | LENGTH OF STAY <u>Lifetime</u> | | CITY OR TOWN <u>Cumberland, Md.</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>15 Mary St.</u> | | | | STREET ADDRESS <u>15 Mary St.</u> | | | |
| 3. NAME OF DECEASED (First) <u>John</u> (Middle) <u>L.</u> (Last) <u>Heller</u> | | | | 4. DATE OF DEATH (Month) <u>I-</u> (Day) <u>6</u> (Year) <u>19 56</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>Sept. 24, 1872</u> | 9. AGE last birthday <u>83</u> yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Blacksmith Railroad</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | Months | Days |
| 11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | Hours | Min. |
| 13. FATHER'S NAME <u>Andrew Heller</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Elizebeth Heir</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>705-05-4741</u> | | 17. INFORMANT & ADDRESS <u>Florence Heller 15 Mary St.</u> | | | |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 260X IMMEDIATE CAUSE (A) <u>Arterio Sclerotic vascular</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>7-8-56</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Disease</u> | | | | <u>to</u> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Diabetes Mellitus</u> | | | | <u>1-6-56</u> | | | |
| 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not white at work <input type="checkbox"/> | | 21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>7-2</u> , 19 <u>56</u> , to <u>1-6-56</u> , that I last saw the deceased alive on <u>1-3-56</u> , and that death occurred at <u>12 noon</u> M., from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>W. F. Williams</u> M.D. | | | | ADDRESS (Street, city, town, state) <u>Cumberland</u> DATE SIGNED <u>1-9-56</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>I-9-56</u> | | NAME OF CEMETERY OR CREMATORY <u>Zion Memorial Cem.</u> | | LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE <u>Walter R. Trout</u> M.D. | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpell</u> | | ADDRESS <u>Cumberland, Md.</u> | |
| DATE <u>1-9-56</u> | | | | | | | |

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 4

28

1. PLACE OF DEATH

COUNTY Allegany

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)TOWN CumberlandLENGTH OF STAY
(In this place)

8 days

HOSPITAL OR
INSTITUTION OR
STREET ADDRESSSacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE MarylandCOUNTY Allegany

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN near Cumberland, ruralSTREET
ADDRESSRt. # 1 Allegany Grove3. NAME OF
DECEASED
(Type or Print)

(First)

(Middle)

(Last)

KarenSueHite4. DATE
OF
DEATH

(Month)

(Day)

(Year)

Jan.41956

5. SEX

F.6. COLOR OR
RACEW.7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)Single

8. DATE OF BIRTH

Aug. 27, 1955

9. AGE last birthday

yrs. 4

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)Infant10b. KIND OF BUSINESS
OR INDUSTRY----

11. BIRTHPLACE (State or foreign country)

Maryland Cumberland12. CITIZEN OF WHAT
COUNTRY?U.S.A.

13. FATHER'S NAME

Harold Hite

14. MOTHER'S MAIDEN NAME

Jean Day Hite15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of service)No

16. SOCIAL SECURITY NO.

None

17. INFORMANT & ADDRESS

Patient's Chart

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

571.0 IMMEDIATE CAUSE

(A)

Uremia

ANTECEDENT CAUSE(S)

DUE TO

DISEASES OR CONDITIONS, IF ANY,
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST.

(B)

Gastroenteritis

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.Acidosis and dehydrationINTERVAL BETWEEN
ONSET AND DEATH5 days2 wk1 1/2 wk

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
While ☐ Not while ☐
at work at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 30, 1955, to Jan 4, 1956, that I last saw the deceased
alive on Jan 3, 1956, and that death occurred at 12:45 A.M. from the causes and on the date stated above.

SIGNATURE

R. A. Reiter

M.D.

ADDRESS (Street, city, town, state)

DATE SIGNED

112 Bedford St., Cumberland, Md. Jan 17, 195623. BURIAL, CREMATION,
REMOVAL (SPECIFY)Burial

DATE THEREOF

Jan 6, 1956

NAME OF CEMETERY OR CREMATORY

Bethel Meth Cemetery

LOCATION (City, town, or county)

Bedford County, Penn.

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Jan 6, 1956Walter R. Frank, M.D.John J. Hafer, Cumberland, Maryland

INSTRUCTIONS

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VS AISC 1-55 10M

VS

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

Wm. D. H. 100

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. CAUSE OF DEATH

7. PLACE OF BIRTH

8. OCCUPATION

9. MARITAL STATUS

10. EDUCATION

11. RELIGION

12. DATE OF BIRTH

13. PLACE OF BIRTH

14. OCCUPATION

15. MARITAL STATUS

16. EDUCATION

17. RELIGION

18. DATE OF BIRTH

19. PLACE OF BIRTH

20. OCCUPATION

21. MARITAL STATUS

22. EDUCATION

23. RELIGION

24. DATE OF BIRTH

25. PLACE OF BIRTH

26. OCCUPATION

27. MARITAL STATUS

28. EDUCATION

29. RELIGION

30. DATE OF BIRTH

31. PLACE OF BIRTH

32. OCCUPATION

33. MARITAL STATUS

34. EDUCATION

35. RELIGION

36. DATE OF BIRTH

37. PLACE OF BIRTH

38. OCCUPATION

39. MARITAL STATUS

40. EDUCATION

41. RELIGION

42. DATE OF BIRTH

43. PLACE OF BIRTH

44. OCCUPATION

45. MARITAL STATUS

46. EDUCATION

47. RELIGION

48. DATE OF BIRTH

49. PLACE OF BIRTH

50. OCCUPATION

51. MARITAL STATUS

52. EDUCATION

53. RELIGION

54. DATE OF BIRTH

55. PLACE OF BIRTH

56. OCCUPATION

57. MARITAL STATUS

58. EDUCATION

59. RELIGION

60. DATE OF BIRTH

61. PLACE OF BIRTH

62. OCCUPATION

63. MARITAL STATUS

64. EDUCATION

65. RELIGION

66. DATE OF BIRTH

67. PLACE OF BIRTH

68. OCCUPATION

69. MARITAL STATUS

70. EDUCATION

71. RELIGION

72. DATE OF BIRTH

73. PLACE OF BIRTH

74. OCCUPATION

75. MARITAL STATUS

76. EDUCATION

77. RELIGION

78. DATE OF BIRTH

79. PLACE OF BIRTH

80. OCCUPATION

81. MARITAL STATUS

82. EDUCATION

83. RELIGION

84. DATE OF BIRTH

85. PLACE OF BIRTH

86. OCCUPATION

87. MARITAL STATUS

88. EDUCATION

89. RELIGION

90. DATE OF BIRTH

91. PLACE OF BIRTH

92. OCCUPATION

93. MARITAL STATUS

94. EDUCATION

95. RELIGION

96. DATE OF BIRTH

97. PLACE OF BIRTH

98. OCCUPATION

99. MARITAL STATUS

100. EDUCATION

101. RELIGION

102. DATE OF BIRTH

103. PLACE OF BIRTH

104. OCCUPATION

105. MARITAL STATUS

106. EDUCATION

107. RELIGION

108. DATE OF BIRTH

109. PLACE OF BIRTH

110. OCCUPATION

111. MARITAL STATUS

112. EDUCATION

113. RELIGION

114. DATE OF BIRTH

115. PLACE OF BIRTH

116. OCCUPATION

117. MARITAL STATUS

118. EDUCATION

119. RELIGION

120. DATE OF BIRTH

121. PLACE OF BIRTH

122. OCCUPATION

123. MARITAL STATUS

124. EDUCATION

125. RELIGION

126. DATE OF BIRTH

127. PLACE OF BIRTH

128. OCCUPATION

129. MARITAL STATUS

130. EDUCATION

131. RELIGION

132. DATE OF BIRTH

133. PLACE OF BIRTH

134. OCCUPATION

135. MARITAL STATUS

136. EDUCATION

137. RELIGION

138. DATE OF BIRTH

139. PLACE OF BIRTH

140. OCCUPATION

141. MARITAL STATUS

142. EDUCATION

143. RELIGION

144. DATE OF BIRTH

145. PLACE OF BIRTH

146. OCCUPATION

147. MARITAL STATUS

148. EDUCATION

149. RELIGION

150. DATE OF BIRTH

151. PLACE OF BIRTH

152. OCCUPATION

153. MARITAL STATUS

154. EDUCATION

155. RELIGION

156. DATE OF BIRTH

157. PLACE OF BIRTH

158. OCCUPATION

159. MARITAL STATUS

160. EDUCATION

161. RELIGION

162. DATE OF BIRTH

163. PLACE OF BIRTH

164. OCCUPATION

165. MARITAL STATUS

166. EDUCATION

167. RELIGION

168. DATE OF BIRTH

169. PLACE OF BIRTH

170. OCCUPATION

171. MARITAL STATUS

172. EDUCATION

173. RELIGION

174. DATE OF BIRTH

175. PLACE OF BIRTH

176. OCCUPATION

177. MARITAL STATUS

178. EDUCATION

179. RELIGION

180. DATE OF BIRTH

181. PLACE OF BIRTH

182. OCCUPATION

183. MARITAL STATUS

184. EDUCATION

185. RELIGION

186. DATE OF BIRTH

187. PLACE OF BIRTH

188. OCCUPATION

189. MARITAL STATUS

190. EDUCATION

191. RELIGION

192. DATE OF BIRTH

193. PLACE OF BIRTH

194. OCCUPATION

195. MARITAL STATUS

196. EDUCATION

197. RELIGION

198. DATE OF BIRTH

199. PLACE OF BIRTH

200. OCCUPATION

201. MARITAL STATUS

202. EDUCATION

203. RELIGION

204. DATE OF BIRTH

205. PLACE OF BIRTH

206. OCCUPATION

207. MARITAL STATUS

208. EDUCATION

209. RELIGION

210. DATE OF BIRTH

211. PLACE OF BIRTH

212. OCCUPATION

213. MARITAL STATUS

214. EDUCATION

215. RELIGION

216. DATE OF BIRTH

217. PLACE OF BIRTH

218. OCCUPATION

219. MARITAL STATUS

220. EDUCATION

221. RELIGION

222. DATE OF BIRTH

223. PLACE OF BIRTH

224. OCCUPATION

225. MARITAL STATUS

226. EDUCATION

227. RELIGION

228. DATE OF BIRTH

229. PLACE OF BIRTH

230. OCCUPATION

231. MARITAL STATUS

232. EDUCATION

233. RELIGION

234. DATE OF BIRTH

235. PLACE OF BIRTH

236. OCCUPATION

237. MARITAL STATUS

238. EDUCATION

239. RELIGION

240. DATE OF BIRTH

241. PLACE OF BIRTH

242. OCCUPATION

243. MARITAL STATUS

244. EDUCATION

245. RELIGION

246. DATE OF BIRTH

247. PLACE OF BIRTH

248. OCCUPATION

249. MARITAL STATUS

250. EDUCATION

251. RELIGION

252. DATE OF BIRTH

253. PLACE OF BIRTH

254. OCCUPATION

255. MARITAL STATUS

256. EDUCATION

257. RELIGION

258. DATE OF BIRTH

259. PLACE OF BIRTH

260. OCCUPATION

261. MARITAL STATUS

262. EDUCATION

263. RELIGION

264. DATE OF BIRTH

265. PLACE OF BIRTH

266. OCCUPATION

267. MARITAL STATUS

268. EDUCATION

269. RELIGION

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00042

29

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|---|-------------------------------|--|---------------------------------|--|-----------------|---|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | STATE <u>Maryland</u> COUNTY <u>Allegany</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) | | CITY (If outside corporate limits, write RURAL and give nearest town) | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | TOWN <u>Cumberland</u> | | TOWN <u>Cumberland</u> | |
| TOWN <u>Cumberland</u> | | <u>22 days</u> | | STREET ADDRESS (If rural give location) | | STREET ADDRESS | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u> | | | | <u>302 Bedford Street</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <u>Williet F.</u> (Middle) <u>Houck</u> (Last) | | | | (Month) <u>1</u> (Day) <u>2</u> (Year) <u>1956</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u> | 8. DATE OF BIRTH <u>8-20-82</u> | 9. AGE last birthday <u>73</u> Yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own house</u> | | 11. BIRTHPLACE (State or foreign country) <u>Piedmont West Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u> | |
| 13. FATHER'S NAME <u>J. Holmes Houck</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Jane Anne Powell</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT & ADDRESS <u>Mrs. Jane G. Cessna, Cumberland Md.</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | <u>22 days</u> | | | |
| IMMEDIATE CAUSE (A) <u>Cerebral Apoplexy</u> | | | | | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE | | | | | | | |
| STATING UNDERLYING CAUSE LAST. DUE TO | | | | | | | |
| (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) | | 21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Dec 11, 1955</u> , to <u>Jan 2, 1956</u> , that I last saw the deceased alive on <u>1-2-56</u> , 19 <u>56</u> , and that death occurred at <u>5:25 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>[Signature]</u> | | M.D. <u>[Signature]</u> | | ADDRESS (Street, city, town, state) <u>Cumberland Md</u> | | DATE SIGNED <u>1-3-56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>Jan 4 1956</u> | | NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u> | |
| 24. REC'D BY REGISTRAR <u>Jan 13, 1956</u> | | REGISTRAR'S SIGNATURE <u>Walter R. Frank, M.D.</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Right</u> | | ADDRESS <u>Cumberland, Md.</u> | |

CERTIFICATE OF DEATH

Reg. Dist. No.

2. CAUSE OF DEATH (IN ORDER OF PRECEDENCE)

MARYLAND

COUNTY OF BALTIMORE

Ward No.

Block No.

Lot No.

Street No.

City

State

Zip

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

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JAN 4 1956

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1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Within corporate limits

30

CERTIFICATE OF DEATH

00043

Reg. Dist. No. 4

| | | | | | | | |
|---|-------------------------|---|--------------------------|---|------------------------|---|-------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY ALLEGANY | | STATE MARYLAND | | COUNTY ALLEGANY | | | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN CUMBERLAND | | 19 DAYS | | TOWN CUMBERLAND | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL | | | | STREET ADDRESS (If rural give location) 927 FREDERICK STREET | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| JENNINGS <i>George Koon</i> HOUSE | | | | JAN. 7 1956 | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| MALE | WHITE | SINGLE | FEBRUARY 12, 1913 | 42 yrs. | Months | Days | Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Salesman | | Advertising Novelties | | MARYLAND | | U. S. A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| GEORGE L. HOUSE | | | | EMILY J. HOUSE | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| No | | 212-18-1475 | | MEMORIAL HOSPITAL-WARWICK & MEMORIAL AVENUES | | | |
| 18. MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| 293X IMMEDIATE CAUSE (A) | | | | severe Anemia - Cachexia | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | Bilateral Pneumonia - Pleurisy | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO | | | | | | | |
| (C) | | | | | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | Myocarditis | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from Dec 1955, to Jan 1956, that I last saw the deceased alive on Jan 7, 1956, and that death occurred at 4:23 PM, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | | | DATE SIGNED | | | |
| <i>Admiral L. H. H.</i> | | | | 1/10/56 | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | |
| Burial | | | | 1/10/56 | | Odd Fellows Cemetery | |
| 24. REC'D BY REGISTRAR | | | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | |
| DATE 1/10/56 | | | | Walter R. Frantz M.D. | | John J. Hafer Cumberland Md | |

CERTIFICATE OF DEATH

NAME OF DECEASED: **JOHN J. HOOVER**
 PLACE OF DEATH: **HOME**
 DATE OF DEATH: **1935**
 TIME OF DEATH: **10:00 AM**
 CAUSE OF DEATH: **HEART DISEASE**
 PLACE OF BIRTH: **NEW YORK**
 DATE OF BIRTH: **1895**
 SEX: **MALE**
 COLOR: **WHITE**
 OCCUPATION: **GOVERNMENT EMPLOYEE**
 MARITAL STATUS: **MARRIED**
 PLACE OF DEATH: **HOME**
 STREET: **1000 14th Street**
 CITY: **BALTIMORE**
 COUNTY: **BALTIMORE**
 STATE: **MARYLAND**

DECEASED'S RESIDENCE: **1000 14th Street**
 CITY: **BALTIMORE**
 COUNTY: **BALTIMORE**
 STATE: **MARYLAND**

DECEASED'S OCCUPATION: **GOVERNMENT EMPLOYEE**
 EMPLOYER: **U.S. DEPARTMENT OF JUSTICE**
 ADDRESS: **1000 14th Street**
 CITY: **BALTIMORE**
 COUNTY: **BALTIMORE**
 STATE: **MARYLAND**

DECEASED'S DATE OF BIRTH: **1895**
 PLACE OF BIRTH: **NEW YORK**
 SEX: **MALE**
 COLOR: **WHITE**
 OCCUPATION: **GOVERNMENT EMPLOYEE**
 MARITAL STATUS: **MARRIED**
 PLACE OF DEATH: **HOME**
 STREET: **1000 14th Street**
 CITY: **BALTIMORE**
 COUNTY: **BALTIMORE**
 STATE: **MARYLAND**

DECEASED'S CAUSE OF DEATH: **HEART DISEASE**
 PLACE OF DEATH: **HOME**
 STREET: **1000 14th Street**
 CITY: **BALTIMORE**
 COUNTY: **BALTIMORE**
 STATE: **MARYLAND**

DECEASED'S DATE OF DEATH: **1935**
 TIME OF DEATH: **10:00 AM**
 PLACE OF DEATH: **HOME**
 STREET: **1000 14th Street**
 CITY: **BALTIMORE**
 COUNTY: **BALTIMORE**
 STATE: **MARYLAND**

DECEASED'S OCCUPATION: **GOVERNMENT EMPLOYEE**
 EMPLOYER: **U.S. DEPARTMENT OF JUSTICE**
 ADDRESS: **1000 14th Street**
 CITY: **BALTIMORE**
 COUNTY: **BALTIMORE**
 STATE: **MARYLAND**

DECEASED'S DATE OF BIRTH: **1895**
 PLACE OF BIRTH: **NEW YORK**
 SEX: **MALE**
 COLOR: **WHITE**
 OCCUPATION: **GOVERNMENT EMPLOYEE**
 MARITAL STATUS: **MARRIED**
 PLACE OF DEATH: **HOME**
 STREET: **1000 14th Street**
 CITY: **BALTIMORE**
 COUNTY: **BALTIMORE**
 STATE: **MARYLAND**

DECEASED'S CAUSE OF DEATH: **HEART DISEASE**
 PLACE OF DEATH: **HOME**
 STREET: **1000 14th Street**
 CITY: **BALTIMORE**
 COUNTY: **BALTIMORE**
 STATE: **MARYLAND**

DECEASED'S DATE OF DEATH: **1935**
 TIME OF DEATH: **10:00 AM**
 PLACE OF DEATH: **HOME**
 STREET: **1000 14th Street**
 CITY: **BALTIMORE**
 COUNTY: **BALTIMORE**
 STATE: **MARYLAND**

DECEASED'S OCCUPATION: **GOVERNMENT EMPLOYEE**
 EMPLOYER: **U.S. DEPARTMENT OF JUSTICE**
 ADDRESS: **1000 14th Street**
 CITY: **BALTIMORE**
 COUNTY: **BALTIMORE**
 STATE: **MARYLAND**

DECEASED'S DATE OF BIRTH: **1895**
 PLACE OF BIRTH: **NEW YORK**
 SEX: **MALE**
 COLOR: **WHITE**
 OCCUPATION: **GOVERNMENT EMPLOYEE**
 MARITAL STATUS: **MARRIED**
 PLACE OF DEATH: **HOME**
 STREET: **1000 14th Street**
 CITY: **BALTIMORE**
 COUNTY: **BALTIMORE**
 STATE: **MARYLAND**

DECEASED'S CAUSE OF DEATH: **HEART DISEASE**
 PLACE OF DEATH: **HOME**
 STREET: **1000 14th Street**
 CITY: **BALTIMORE**
 COUNTY: **BALTIMORE**
 STATE: **MARYLAND**

DECEASED'S DATE OF DEATH: **1935**
 TIME OF DEATH: **10:00 AM**
 PLACE OF DEATH: **HOME**
 STREET: **1000 14th Street**
 CITY: **BALTIMORE**
 COUNTY: **BALTIMORE**
 STATE: **MARYLAND**

DECEASED'S OCCUPATION: **GOVERNMENT EMPLOYEE**
 EMPLOYER: **U.S. DEPARTMENT OF JUSTICE**
 ADDRESS: **1000 14th Street**
 CITY: **BALTIMORE**
 COUNTY: **BALTIMORE**
 STATE: **MARYLAND**

BUREAU V. S.

JAN 13 1935

RECEIVED

SMITHSONIAN

00044

31 **CERTIFICATE OF DEATH**

Reg. Dist. No. 4

Item 7, Film 92 1-31-56 et

1. PLACE OF DEATH

COUNTY Allegany
CITY (If outside corporate limits, write RURAL
OR end give nearest town)
TOWN CumberlandMARYLAND
LENGTH OF STAY
(in this place)
1 HrHOSPITAL OR
INSTITUTION OR
STREET ADDRESSMemorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL end give nearest town)
OR
TOWN CumberlandSTREET
ADDRESS (If rural give location)
119 Cumberland St.3. NAME OF
DECEASED
(Type or Print)

(First)

(Middle)

(Last)

EmmaLouiseThle4. DATE
OF
DEATH

(Month)

(Day)

(Year)

January 619 56

5. SEX

6. COLOR OR
RACE7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
SEPARATED

8. DATE OF BIRTH

9. AGE last birthday

IF UNDER 1 YEAR

IF UNDER 24 HRS.

FemaleWhiteSeparatedMay 4, 190946 yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)10b. KIND OF BUSINESS
OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT
COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Ralph B ShuckMary Campbell15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS

No216 22 6984Mr William Shuck Cumberland, Md.

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

18. MEDICAL CERTIFICATION

INTERVAL BETWEEN
ONSET AND DEATH416X

IMMEDIATE CAUSE (A)

(A)

Cerebral Embolus15 minutes

ANTECEDENT CAUSE(S)

DUE TO

DISEASES OR CONDITIONS, IF ANY,
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST,

(B)

DUE TO

(C)

Auricular Fibrillation10 yrsRheumatic Heart Disease30 yrs.II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.Coronary Stenosis + Insufficiency30 yrs

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES ☐ NO ☒21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OR INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED

21f. HOW DID INJURY OCCUR?

While ☐ Not while ☐
at work ☐ at work ☐22. I hereby certify that I attended the deceased from 1952, to Jan 6, 1956, that I last saw the deceasedalive on Jan 3, 1956, and that death occurred at 10:45 A.M. from the causes and on the date stated above.

SIGNATURE

ADDRESS (Street, city, town, state)

DATE SIGNED

David G. McNamee

M.D.

59 Green St Cumberland Md 1/8/5623. BURIAL, CREMATION,
REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial1/9/56Rose Hill CemeteryCumberlandMaryland

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Jan. 9, 1956Winter R. Frantz, M.D.Louis Stein, Inc. Cumberland, Md.

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

78

CERTIFICATE OF DEATH

00045

Reg. Dist. No. 6

| | | | | | | | |
|---|------------------|--|----------------------|---|-----------------|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Allegany</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Westernport</u> | | | | TOWN <u>Westernport</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| <u>121 Johnson Street.</u> | | | | <u>121 Johnson Street.</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <u>Mary</u> (Middle) <u>Ann</u> (Last) <u>Jamesson.</u> | | | | (Month) <u>January</u> (Day) <u>19</u> (Year) <u>1956.</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <u>Female</u> | <u>White</u> | <u>Widowed.</u> | <u>Dec. 7, 1871.</u> | <u>84</u> yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>Housewife.</u> | | | | <u>Lonaconing, Maryland.</u> | | <u>USA.</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>James Tonry</u> | | | | <u>Rebecca Broadwater.</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| <u>No.</u> | | | | <u>Westernport,</u>
<u>Mrs. Nellie Cassell, Maryland.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 260X IMMEDIATE CAUSE (A) <u>nephritis</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>myocarditis</u> | | | | <u>2 wks.</u> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>D. diabetes Mellitus</u> | | | | <u>5 yrs.</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>Dec 1, 1955</u> to <u>Jan 19, 1956</u> , that I last saw the deceased alive on <u>Jan 19, 1956</u> , and that death occurred at <u>12:10 PM</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>P. E. Berry</u> M.D. | | | | ADDRESS (Street, city, town, state) <u>Piedmont, W. Va.</u> DATE SIGNED | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>Jan. 23, 1956.</u> | | <u>Philos Cemetery,</u> | | <u>Westernport, Md.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| DATE <u>1-23-56</u> | | <u>Mrs Jean C Kelly</u> | | <u>W. David Fredrick</u> | | <u>PIEDMONT, W. Va.</u> | |

CERTIFICATE OF DEATH

NO

1. PLACE OF DEATH

2. TIME

3. DATE

4. SEX

5. AGE

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF CORONER

12. SIGNATURE OF JURY

13. SIGNATURE OF DEPUTY COMMISSIONER

14. SIGNATURE OF REGISTRAR

15. SIGNATURE OF CLERK

16. SIGNATURE OF CHIEF CLERK

17. SIGNATURE OF ASSISTANT CLERK

18. SIGNATURE OF STENOGRAPHER

19. SIGNATURE OF RECEPTIONIST

20. SIGNATURE OF ATTENDANT

21. SIGNATURE OF NURSE

22. SIGNATURE OF LABORER

23. SIGNATURE OF CLEANER

24. SIGNATURE OF COOK

25. SIGNATURE OF BUTLER

26. SIGNATURE OF VALET

27. SIGNATURE OF GROOM

28. SIGNATURE OF DRIVER

29. SIGNATURE OF MESSENGER

30. SIGNATURE OF PORTER

31. SIGNATURE OF JANITOR

32. SIGNATURE OF WATCHMAN

33. SIGNATURE OF NIGHT WATCHMAN

34. SIGNATURE OF GARDENER

35. SIGNATURE OF PAINTER

36. SIGNATURE OF CARPENTER

37. SIGNATURE OF PLUMBER

38. SIGNATURE OF ELECTRICIAN

39. SIGNATURE OF MECHANIC

40. SIGNATURE OF BLACKSMITH

41. SIGNATURE OF COBBLER

42. SIGNATURE OF HATTER

43. SIGNATURE OF SHOE REPAIRER

44. SIGNATURE OF MILLINER

45. SIGNATURE OF DRESSMAKER

46. SIGNATURE OF HAIR DRESSER

47. SIGNATURE OF BEAUTICIAN

BUREAU V. S.

JAN 24 1956

RECEIVED

SMITHSONIAN

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS THE PROPERTY OF THE STATE OF MARYLAND. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS FOR A PERIOD OF FIFTY YEARS. IT IS TO BE MADE AVAILABLE TO ANY PERSON WHO REQUESTS IT. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS FOR A PERIOD OF FIFTY YEARS. IT IS TO BE MADE AVAILABLE TO ANY PERSON WHO REQUESTS IT.

INSTRUCTIONS

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00046

| | | | | | | | |
|---|------------------|--|-----------------------|---|-----------------|---|--------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | STATE <u>Maryland</u> COUNTY <u>Allegany</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) | | CITY (If outside corporate limits, write RURAL and give nearest town) | |
| CITY <u>Frostburg</u> | | LENGTH OF STAY (In this place) | | TOWN <u>Frostburg</u> | | TOWN <u>Frostburg</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miner's Hospital</u> | | STREET ADDRESS (If rural give location) | | STREET ADDRESS <u>210 First Street</u> | | STREET ADDRESS <u>210 First Street</u> | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| <u>Kim William Keifer</u> | | | | <u>Jan. 5th, 1956</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <u>Male</u> | <u>White</u> | <u>Single</u> | <u>Dec. 7th, 1955</u> | <u>1</u> yrs. | <u>1</u> Months | <u>5</u> Days | <u>19</u> Hours <u>24</u> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| | | | | <u>Maryland</u> | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>Walter Keifer</u> | | | | <u>Virginia Haines</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| (If Yes, give war or dates of service) | | | | | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| IMMEDIATE CAUSE (A) <u>764.5 PNEUMONIA</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>DIARRHEA + ACIDOSIS</u> | | | | | | <u>3 days</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Prematurity</u> | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>12</u> , 19 <u>55</u> , to <u>1/5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/5</u> , 19 <u>56</u> , and that death occurred at <u>6</u> M, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>John C. Sever</u> | | | | ADDRESS (Street, city, town, state) <u>Frostburg, Md.</u> | | DATE SIGNED <u>1/6/56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>1 - 7 - 56</u> | | <u>Johnson's Cemetery</u> | | <u>Garrett County, Md.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| DATE <u>1-7-56</u> | | <u>Miss Nancy H. Rye</u> | | <u>Joseph R. Durst, Frostburg, Md.</u> | | | |

2161192273

RECEIVED

1

INSTRUCTIONS

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VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

00047

Reg. Dist. No. 6

78

| | | | | | | | |
|--|----------------------------------|--|---|---|---|---|--------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Garrett</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)
<u>Westernport</u> | | LENGTH OF STAY (In this place)
<u>52 years</u> | | CITY (If outside corporate limits, write RURAL and give nearest town)
<u>Westernport</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS
<u>Hill Top Drive</u> | | | | STREET ADDRESS (If rural give location)
<u>Hill Top Drive</u> | | | |
| 3. NAME OF DECEASED
(Type or Print) <u>Sarah</u> (First) <u>Victoria</u> (Middle) <u>Keller</u> (Last) | | | | 4. DATE OF DEATH
(Month) (Day) (Year)
<u>Jan 15</u> <u>19</u> <u>56</u> | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
<u>Single</u> | 8. DATE OF BIRTH
<u>29 Sept 1882</u> | 9. AGE last birthday
<u>73</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Domestic</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>- - -</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Lost River, W. Va.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>US</u> | |
| 13. FATHER'S NAME
<u>William Keller</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Mirandy Stewart</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | | 17. INFORMANT & ADDRESS
<u>Mrs. John Wilson, Hill Top Drive Westernport, Md.</u> | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 422.1 IMMEDIATE CAUSE (A) <u>Chronic Myocarditis</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 Year</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio-sclerosis</u> | | | | | | <u>1 Year</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION
<u>None</u> | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)
<u>None</u> | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Nov. 26, 1955</u> , to <u>Jan. 15, 1956</u> , that I last saw the deceased alive on <u>Jan. 12, 1956</u> , and that death occurred at <u>6 P.</u> M, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE
<u>Paul B. Wilson</u> | | | | ADDRESS (Street, city, town, state)
<u>Piedmont, W. Va.</u> | | DATE SIGNED
<u>Jan. 17, 1956</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | | DATE THEREOF
<u>18 Jan 56</u> | | NAME OF CEMETERY OR CREMATORY
<u>Philos Cemetery</u> | | LOCATION (City, town, or county) (State)
<u>Westernport, Md.</u> | |
| 24. REC'D BY REGISTRAR
<u>Jan C. Kelly</u> | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE
<u>E. J. Gyal</u> | | ADDRESS
<u>Westernport, Md.</u> | |
| DATE
<u>1-18-56</u> | | | | | | | |

Outside of
City Limits

95
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00048
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

| | | | |
|---|--------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <u>Allegany</u> | MARYLAND | STATE <u>Md.</u> | COUNTY <u>Allegany</u> |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | LENGTH OF STAY (in this place) | CITY (If outside corporate limits write RURAL and give nearest town) | |
| X TOWN <u>La Vale</u> | | TOWN <u>Rural) Flintstone</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>In auto. Route #40</u> | | STREET ADDRESS (If rural, give location) <u>R.F.D.#2</u> | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | 4. DATE OF DEATH (Month) (Day) (Year) | |
| (Type or Print) <u>Paul Wesley Kennedy</u> | | <u>Jan. 20 19 56</u> | |
| 5. SEX: <u>male</u> | 6. COLOR OR RACE: <u>white</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u> | 8. DATE OF BIRTH: <u>Jan 22-1932</u> |
| 9. AGE last birthday: <u>23</u> yrs. | | 10. BIRTHPLACE (State or foreign country): <u>Little Orleans, Md.</u> | |
| 11. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>B&O. R.R. Brakeman</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME: <u>John Wesley Kennedy</u> | | 14. MOTHER'S MAIDEN NAME: <u>Emma Frances Trail</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>W.W.2</u> | | 16. SOCIAL SECURITY No.: <u>218-24-8622</u> | |
| 17. INFORMANT & ADDRESS: <u>R.F.D.#2 (Father) John W. Kennedy, Flintstone, Md.</u> | | | |

| | | |
|--|-----------------------------------|---|
| 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH
<u>sudden</u> |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | |
| Immediate cause (a) <u>Subdural</u> | <u>hemorrhage (auto accident)</u> | |
| DUE TO | | |
| Antecedent cause(s) (b) <u>basal fracture of the skull also had</u> | | |
| Diseases or conditions, if any, giving rise to the above cause DUE TO | | |
| stating underlying cause last (c) <u>fractured, inferior & superior maxillary (right)</u> | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>& puncture wound in neck.</u> | | |

| | | | | |
|--|---|---|---|--|
| 19a. DATE OF OPERATION: <u>Jan. 23, 1956</u> | | 19b. MAJOR FINDING OF OPERATION: | | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <u>highway 40</u> | 21c. (City or town) (County) (State) | <u>LaVale Allegany Md.</u> | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Jan. 20/56 A.M.</u> | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 21f. HOW DID INJURY OCCUR? <u>Car ran off wrong side of road & hit a culvert.</u> | | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | |
| SIGNATURE <u>H.V. Deming M.D.</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Jan. 20/56</u> | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | M. D. ASSISTANT MEDICAL EXAM. <u>James F. Scarpelli</u> | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u> | DATE THEREOF <u>Jan. 24, 1956</u> | NAME OF CEMETERY OR CREMATORY <u>Pinet Plains Cemetery</u> | LOCATION (City, town, or county) (State) <u>Pinet Plains Maryland</u> | |
| DATE REC'D BY LOCAL REG. <u>Jan. 23, 1956</u> | REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u> | 24. FUNERAL DIRECTOR <u>James F. Scarpelli, Cumberland, Md.</u> | | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 24 1896

BUREAU V. S.

32

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|---|------------------|--|-----------------------------------|---|---|--|------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY ALLEGANY | | MARYLAND | | STATE PA. | | COUNTY Somerset | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN CUMBERLAND | | 55 DAYS | | TOWN WELLERSBURG | | 75X-3 | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| MEMORIAL HOSPITAL
MEMORIAL AVE. | | | | | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| MR CLARENCE KENNEL | | | | JAN. 12 1956 | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday yrs. | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. |
| MALE | WHITE | MARRIED | Aug. 12, 1882 | 73 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| Retired Farmer | | | Own Farm | | PENN. | | U.S.A. |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| SAMUEL KENNEL | | | | CAROLINE ALBRIGHT, Caroline | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| No | | NONE | | MEMORIAL HOSPITAL, CUMBERLAND, MD. | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 153X IMMEDIATE CAUSE (A) Carcinoma colon with generalized | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSE(S) DUE TO Abdominal Carcinomatosis | | | | | | 1+ years | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO | | | | | | | |
| (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| Nov 25, 1955 | | Carcinoma colon - metastases retroperitoneal nodes | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from Nov 18, 1955, to Jan 12, 1956, that I last saw the deceased alive on Jan 12, 1956, and that death occurred at 9:17 PM, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | | | ADDRESS (Street, city, town, state) | | DATE SIGNED | |
| C. M. Fawcett | | | | Cumberland Md | | Jan 13 '56 | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| Burial | | Jan. 15, 1956 | | Cook Cemetery | | Wellersburg, Pa. | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| Jan 14, 1956 | | Winters R. Gantz, Md | | Stephen S. Taylor | | Hyndman, Pa. | |

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

Page Four

1. NAME OF DECEASED

ALLEN, Y.

10 DAYS

1. DATE OF DEATH
2. TIME OF DEATH

1. PLACE OF DEATH

1. NAME OF DECEASED

1. NAME OF DECEASED

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BUREAU V. S.

JAN 17 1958

RECEIVED

SMITHSONIAN INSTITUTION

THE NATIONAL MUSEUM

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00050

CERTIFICATE OF DEATH

Reg. Dist. No. 9

| | | | | | | | |
|--|------------------------------|--|--|--|---|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Ma.</u> | | COUNTY <u>Allegany</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN <u>Frostburg</u> | | LENGTH OF STAY
(in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN <u>Frostburg</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>86 West Main Street</u> | | | | STREET ADDRESS (If rural give location)
<u>86 West Main</u> | | | |
| 3. NAME OF DECEASED
(Type or Print) <u>James P. Kenney</u> | | | | 4. DATE OF DEATH
1 28 19 56 | | | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u> | 8. DATE OF BIRTH
<u>Feb. 18th, 1881</u> | 9. AGE last birthday
<u>74</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own business</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Westernport</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>James Kenney</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Catherine Eagan</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.) <u>No.</u> (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>214-32-3533</u> | | 17. INFORMANT & ADDRESS
<u>Bernard Kenney 86 W. Main Frostburg, Ma.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>Hours</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Gen. Arteriosclerosis</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>10</u> <u>19 55</u> , to <u>1/31</u> , <u>19 56</u> , that I last saw the deceased alive on <u>12</u> , <u>19 55</u> , and that death occurred at <u>3 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>John C. Owen</u> | | | | ADDRESS (Street, city, town, state) <u>25 East Main Frostburg, Md.</u> | | | |
| DATE <u>1-31-56</u> | | | | DATE SIGNED <u>1/31/56</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | | DATE THEREOF
<u>1 - 31 - 56</u> | | NAME OF CEMETERY OR CREMATORY
<u>St. Michael's Cemetery</u> | | LOCATION (City, town, or county) (State)
<u>Frostburg Md.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE
<u>Miss Nancy H. Roe</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE
<u>Richard H. Montesant</u> | | ADDRESS
<u>25 East Main Frostburg, Md.</u> | |

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 12

Form 100-100

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF FUNERAL HOME

17. SIGNATURE OF CHURCH OFFICIAL

18. SIGNATURE OF CEMETERY OFFICIAL

19. SIGNATURE OF OTHER OFFICIAL

20. SIGNATURE OF OTHER OFFICIAL

21. SIGNATURE OF OTHER OFFICIAL

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60. SIGNATURE OF OTHER OFFICIAL

BUREAU V. S.

FEB 6 1956

RECEIVED

NOTICE

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 12

00051

33
CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH

COUNTY

Allegany

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)
TOWN

Cumberland

LENGTH OF STAY
(If this place)
3/30/51HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE

Maryland

COUNTY

Allegany

CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN

Cumberland

STREET
ADDRESS

(If rural give location)

509 Williams Street

3. NAME OF
DECEASED
(Type or Print)

(First)

Frank

(Middle)

N.

(Last)

Kesler

4. DATE
OF
DEATH

(Month)

(Day)

(Year)

January 19, 19 56

5. SEX

Male

6. COLOR OR
RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)

Widower

8. DATE OF BIRTH

1/26/1874

9. AGE last birthday

81

yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)

Retired - Car Man - B. & O.

10b. KIND OF BUSINESS
OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

West Virginia (Morgan County) U. S. A.

12. CITIZEN OF WHAT
COUNTRY?

13. FATHER'S NAME

John Kesler

14. MOTHER'S MAIDEN NAME

Ella Norton

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

705-09-6687

17. INFORMANT & ADDRESS

Allegany County Infirmary Records

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X

IMMEDIATE CAUSE (A)

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY,
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

18. MEDICAL CERTIFICATION

Cerebral Thrombosis

Chronic Hypertension

Pulmonary Hypostasis

Cerebral Arteriosclerosis

INTERVAL BETWEEN
ONSET AND DEATH

20 mos.

?

?

?

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED

While ☐ Not while ☐at work ☐ at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr. 17, 1954, to Jan. 19, 1956, that I last saw the deceased
alive on Jan. 19, 1956, and that death occurred at 11:45 P.M. from the causes and on the date stated above.

SIGNATURE

James B. McLean M.D.

ADDRESS (Street, city, town, state)

49 Greene St.

DATE SIGNED

1-20-56

23. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

DATE THEREOF

1/23/56

NAME OF CEMETERY OR CREMATORY

St. Patrick Cemetery

LOCATION (City, town, or county)

Cumberland

(State)

Maryland

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

Walter R. Frantz, M.D.

25. FUNERAL DIRECTOR'S SIGNATURE

Louis Stein, Inc. Cumberland, Md.

ADDRESS

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

RECEIVED
JAN 21

34

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|--|----------------------------------|--|---|---|--------------------------------|--|--------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>MD.</u> | | COUNTY <u>Allegany</u> | |
| CITY <u>02 Cumberland</u>
(If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY
(in this place)
<u>40 years</u> | | CITY <u>02 Cumberland</u>
(If outside corporate limits, write RURAL and give nearest town) | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS
<u>203 Fayette St.</u> | | | | STREET ADDRESS
<u>203 Fayette St.</u> | | (If rural give location) | |
| 3. NAME OF DECEASED
(Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <u>Lillian</u> (Middle) <u>MacDonald</u> (Last) <u>King</u> | | | | (Month) <u>Jan.</u> (Day) <u>4</u> (Year) <u>19 56</u> | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
<u>Widow</u> | 8. DATE OF BIRTH
<u>Aug. 30-1870</u> | 9. AGE last birthday
<u>85</u> yrs. | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own Home</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Cumberland, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Charles Robb</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Josephine Wolfe</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>none</u> | | 17. INFORMANT & ADDRESS
<u>Md. (sister) Mary Helen Robb, Cumberland,</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
<u>4221</u> IMMEDIATE CAUSE (A) <u>Myocardial failure</u> | | | | | | <u>Gradual</u> | |
| ANTECEDENT CAUSE(S) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B) <u>Chronic myocarditis</u> | | | | | | <u>10 years</u> | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C) <u>Arteriosclerosis</u> | | | | | | <u>?</u> | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) | | (County) (State) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Jan. 4</u> , 19 <u>56</u> , to <u>Jan. 4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan. 4</u> , 19 <u>56</u> , and that death occurred at <u>2:40 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE
<u>H.V. Deming M.D.</u> | | | | ADDRESS (Street, city, town, state)
<u>240 N. Center St. Cumberland, Allegany, Md.</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | | DATE THEREOF
<u>Jan. 7, 1956</u> | | NAME OF CEMETERY OR CREMATORY
<u>Rose Hill Cemetery</u> | | LOCATION (City, town, or county) (State)
<u>Cumberland, Maryland.</u> | |
| 24. REC'D BY REGISTRAR
<u>Jan. 6, 1956</u> | | REGISTRAR'S SIGNATURE
<u>Walter R. Frantz, M.D.</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE
<u>Charles L. George, Cumberland, Maryland.</u> | | | |

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

FILE NO. 12

1. NAME OF DECEASED

2. SEX

3. AGE

4. RACE

5. BIRTH DATE

6. BIRTH PLACE

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF DEATH

10. CAUSE OF DEATH

11. MEDICAL ATTENDANCE

12. MANNER OF DEATH

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF PHYSICIAN

15. MEDICAL CERTIFICATION

16. SIGNATURE OF DECEASED

17. SIGNATURE OF WITNESSES

18. SIGNATURE OF CLERK

19. SIGNATURE OF JURY

20. SIGNATURE OF COURT

21. SIGNATURE OF SHERIFF

22. SIGNATURE OF CONSTABLE

23. SIGNATURE OF JAILER

24. SIGNATURE OF PRISONER

25. SIGNATURE OF GUARD

26. SIGNATURE OF WARDEN

27. SIGNATURE OF CHIEF CLERK

28. SIGNATURE OF DEPUTY CHIEF CLERK

29. SIGNATURE OF ASSISTANT CLERK

30. SIGNATURE OF CLERICAL ASSISTANT

31. SIGNATURE OF RECEPTIONIST

32. SIGNATURE OF TELEPHONE OPERATOR

33. SIGNATURE OF MAIL ROOM CLERK

34. SIGNATURE OF RECORDS CLERK

35. SIGNATURE OF FILE CLERK

36. SIGNATURE OF INDEXING CLERK

37. SIGNATURE OF QUALITY CONTROL CLERK

38. SIGNATURE OF COMPLIANCE CLERK

39. SIGNATURE OF TRAINING CLERK

40. SIGNATURE OF EVALUATION CLERK

41. SIGNATURE OF RESEARCH CLERK

42. SIGNATURE OF STATISTICS CLERK

43. SIGNATURE OF PUBLIC AFFAIRS CLERK

44. SIGNATURE OF COMMUNITY RELATIONS CLERK

45. SIGNATURE OF OUTREACH CLERK

46. SIGNATURE OF EVALUATION CLERK

47. SIGNATURE OF RESEARCH CLERK

48. SIGNATURE OF STATISTICS CLERK

49. SIGNATURE OF PUBLIC AFFAIRS CLERK

50. SIGNATURE OF COMMUNITY RELATIONS CLERK

51. SIGNATURE OF OUTREACH CLERK

52. SIGNATURE OF EVALUATION CLERK

53. SIGNATURE OF RESEARCH CLERK

54. SIGNATURE OF STATISTICS CLERK

55. SIGNATURE OF PUBLIC AFFAIRS CLERK

56. SIGNATURE OF COMMUNITY RELATIONS CLERK

57. SIGNATURE OF OUTREACH CLERK

58. SIGNATURE OF EVALUATION CLERK

59. SIGNATURE OF RESEARCH CLERK

60. SIGNATURE OF STATISTICS CLERK

61. SIGNATURE OF PUBLIC AFFAIRS CLERK

62. SIGNATURE OF COMMUNITY RELATIONS CLERK

63. SIGNATURE OF OUTREACH CLERK

64. SIGNATURE OF EVALUATION CLERK

65. SIGNATURE OF RESEARCH CLERK

66. SIGNATURE OF STATISTICS CLERK

67. SIGNATURE OF PUBLIC AFFAIRS CLERK

68. SIGNATURE OF COMMUNITY RELATIONS CLERK

69. SIGNATURE OF OUTREACH CLERK

70. SIGNATURE OF EVALUATION CLERK

71. SIGNATURE OF RESEARCH CLERK

72. SIGNATURE OF STATISTICS CLERK

73. SIGNATURE OF PUBLIC AFFAIRS CLERK

74. SIGNATURE OF COMMUNITY RELATIONS CLERK

75. SIGNATURE OF OUTREACH CLERK

76. SIGNATURE OF EVALUATION CLERK

77. SIGNATURE OF RESEARCH CLERK

78. SIGNATURE OF STATISTICS CLERK

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241. SIGNATURE OF PUBLIC AFFAIRS CLERK

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00053

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 9

| | | | | | |
|---|-------------------|--|--|--|------------------------------|
| 1. PLACE OF DEATH: | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | |
| COUNTY | Allegany | | MARYLAND | STATE | Md. |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | Frostburg | | LENGTH OF STAY (in this place) | CITY (If outside corporate limits write RURAL and give nearest town) | Frostburg |
| TOWN | Frostburg | | 1 yr. | TOWN | Frostburg |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | 8 Charles St. | | STREET ADDRESS | (If rural, give location)
8 Charles St. | |
| 3. NAME OF DECEASED: | | | 4. DATE OF DEATH | | |
| (First) | (Middle) | (Last) | (Month) | (Day) | (Year) |
| Paul | Edward | Knott | Jan. | 15 | 19 56 |
| (Type or Print) | | | | | |
| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH: | 9. AGE last birthday: | 10. IF UNDER 1 YEAR |
| Male | white | married | Oct. 23-1921 | 34 yrs. | Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, say even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): | 12. CITIZEN OF WHAT COUNTRY? |
| Sawyer box shop | | | W. Va. Pulp & P. Co. | Beryl, W. Va. | U.S.A. |
| 13. FATHER'S NAME: | | | 14. MOTHER'S MAIDEN NAME: | | |
| William Edward Knott | | | Margaret Miller | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | | 16. SOCIAL SECURITY No.: | | |
| no | | | 232-26-2578 | | |
| | | | 17. INFORMANT & ADDRESS: | | |
| | | | (wife) Eleanor Knott, Frostburg, Md. | | |

| | | | | | |
|--|--|--|--|--|--|
| 18. MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | | | |
| 420-1 Immediate cause (a) Coronary occlusion | | | | sudden | |
| Antecedent cause(s) (b) Coronary sclerosis | | | | ? | |
| Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | |
| 19a. DATE OF OPERATION: | | 19b. MAJOR FINDING OF OPERATION: | | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY | | 21c. (City or town) (County) (State) | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | |
| SIGNATURE | | CHIEF MEDICAL EXAMINER | | DATE SIGNED | |
| H. V. Deming M.D. | | M. D. | | Jan. 16-1956 | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): | | DATE THEREOF | | LOCATION (City, town, or county) (State) | |
| Burial | | Jan 18-1956 | | Westonport, Md. | |
| DATE REC'D BY LOCAL REG. | | REGISTRAR'S SIGNATURE | | 24. FUNERAL DIRECTOR ADDRESS | |
| 1-18-56 | | Mr. Nancy A. Roe | | Joseph R. Dunsen Sr. | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 24 1896

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

| | | | | | | | |
|--|-------------------|---|--------------------|--|-----------------|--|------------------|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Md.</u> | | COUNTY <u>Allegany</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits write RURAL and give nearest town) | | OR | |
| TOWN <u>Cumberland</u> | | <u>1 day</u> | | TOWN <u>Cumberland</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u> | | | | STREET ADDRESS (If rural, give location) <u>439 Waverly Terrace</u> | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| (Type or Print) <u>Nellie Beatrice Koerner</u> | | | | <u>Jan. 16 19 56</u> | | | |
| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: | 9. AGE last birthday: | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <u>female</u> | <u>white</u> | <u>single</u> | <u>July 5-1949</u> | <u>6</u> yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>student</u> | | 10b. KIND OF BUSINESS OR INDUSTRY: | | 11. BIRTHPLACE (State or foreign country): <u>Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME: <u>James K. Koerner</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Margaret Miller</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> | | 16. SOCIAL SECURITY No.: <u>none</u> | | 17. INFORMANT & ADDRESS: <u>Memorial Hospital records.</u> | | | |

| | | |
|---|--|----------------------------------|
| 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | |
| <u>916.0 Shock.also 2nd.& 3rd.degree burns of body.</u> | | <u>1 day</u> |
| Immediate cause (a) DUE TO | | |
| Antecedent cause(s) (b) DUE TO | | |
| Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | |

| | | |
|-------------------------|----------------------------------|--|
| 19a. DATE OF OPERATION: | 19b. MAJOR FINDING OF OPERATION: | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
|-------------------------|----------------------------------|--|

| | | |
|--|---|---|
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 21b. PLACE (Home, farm, factory, street, office bldg., etc.,) OF INJURY <u>home</u> | 21c. (City or town) (County) (State) <u>Cumberland Allegany Md.</u> |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Jan. 15-1956 A.M.</u> | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 21f. HOW DID INJURY OCCUR? <u>Climbed on chair Reached over gas range, clothes caught fire from open flame on gas stove</u> |

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H.V. Deming M.D. CHIEF MEDICAL EXAMINER ☐ DATE SIGNED Jan. 16-1956
DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐

| | | | |
|---|--|---|--|
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u> | DATE THEREOF <u>Jan. 18, 1956</u> | DATE OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u> | LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u> |
| DATE REC'D BY LOCAL REG <u>Jan. 17, 1956</u> | REGISTRAR'S SIGNATURE <u>Walter K. Frank, M.D.</u> | 24. FUNERAL DIRECTOR <u>H. Lee Slavy</u> | ADDRESS <u>" "</u> |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 18 1956
BUREAU V. S.

1 INSTRUCTIONS TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

96
CERTIFICATE OF DEATH

Reg. Dist. No. 6

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Allegany</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Luke,</u> | | | | TOWN <u>Luke,</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Railroad Street.</u> | | | | STREET ADDRESS (If rural give location) <u>Railroad Street.</u> | | | |
| 3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Thomas Joseph Laughlin.</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>January 23, 19 56.</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u> | | 8. DATE OF BIRTH <u>May 29, 1890.</u> | |
| | | | | 9. AGE last birthday <u>65</u> yrs. | | 10. IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 Hrs. (Hours) (Min.) | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Windom, West Virginia.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u> | |
| 13. FATHER'S NAME <u>Daniel Laughlin.</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Ann Carey.</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> | | 16. SOCIAL SECURITY NO. (If Yes, give war or dates of service) | | 17. INFORMANT & ADDRESS <u>Charles Laughlin, Luke, Md.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| IMMEDIATE CAUSE (A) <u>592X</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 Years</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE | | | | | | | |
| STATING UNDERLYING CAUSE LAST, DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION <u>None</u> | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>None</u> | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Mar 10, 1954</u> , to <u>Jan 23, 1956</u> , that I last saw the deceased alive on <u>Jan 21, 1956</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Paul R Wilson</u> | | | | ADDRESS (Street, city, town, state) <u>Piedmont, W. Va.</u> | | DATE SIGNED <u>Jan 23, 1956</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>Jan. 26, 1956.</u> | | NAME OF CEMETERY OR CREMATORY <u>St. Peters' Cemetery,</u> | | LOCATION (City, town, or county) (State) <u>Westernport, Alle. Md.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE <u>John C. Kelly</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Howard Fiedler</u> | | ADDRESS <u>Piedmont, W. Va.</u> | |
| DATE <u>1-25-56</u> | | | | | | | |

CERTIFICATE OF DEATH

28

1. Usual Residence of the Deceased

2. Date of Death

3. Place of Death

4. Cause of Death

5. Nature of Injury

6. Name of Physician

7. Name of Hospital

8. Name of Doctor

9. Name of Nurse

10. Name of Attending Physician

11. Name of Hospital

12. Name of Doctor

13. Name of Nurse

14. Name of Attending Physician

15. Name of Hospital

16. Name of Doctor

17. Name of Nurse

18. Name of Attending Physician

19. Name of Hospital

20. Name of Doctor

21. Name of Nurse

22. Name of Attending Physician

23. Name of Hospital

24. Name of Doctor

25. Name of Nurse

26. Name of Attending Physician

27. Name of Hospital

28. Name of Doctor

29. Name of Nurse

30. Name of Attending Physician

31. Name of Hospital

32. Name of Doctor

33. Name of Nurse

34. Name of Attending Physician

35. Name of Hospital

36. Name of Doctor

37. Name of Nurse

38. Name of Attending Physician

39. Name of Hospital

40. Name of Doctor

41. Name of Nurse

42. Name of Attending Physician

43. Name of Hospital

BUREAU V. S.

JAN 26 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|---|------------------|--|-------------------------|---|-----------------|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY ALLEGANY | | STATE MARYLAND | | COUNTY ALLEGANY | | | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN CUMBERLAND | | 2 DAYS | | TOWN CUMBERLAND | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL | | | | STREET ADDRESS 864 SPERRY TERRACE | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | | | 4. DATE (Month) (Day) (Year) | | | |
| JOHN THOMAS LAW | | | | DEATH JANUARY 11, 1956 | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| MALE | WHITE | SINGLE | October 14, 1888 | 67 yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Retired coalminer | | Coal Industry | | W. VA. Germania | | U. S. A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| CHARLES LAW | | | | ANNA E. SWADLEY | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| Yes. W. W. I. | | 236-01-2046 | | MEMORIAL AVE. Mrs. John M. Jankoy, Cumberland, Md. | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| IMMEDIATE CAUSE (A) Anterior subcoronary cardio vascular disease | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSE(S) DUE TO (B) Emphysema | | | | | | 6 yrs. | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Gastric ulcer | | | | | | ? | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Perforated gastric ulcer | | | | | | 12 hrs. | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 1-11-56 | | Perforated gastric ulcer | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| | | INJURY street, office bldg., etc.) | | (City or town) | | (County) (State) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | M. | | | | | |
| 22. I hereby certify that I attended the deceased from 1-9 , 19 56 , to 1-11 , 19 56 , that I last saw the deceased alive on 1-11 , 19 56 , and that death occurred at 9:55 P. M., from the causes and on the date stated above. | | | | | | | |
| SIGNATURE D. B. Jankoy | | | | DATE SIGNED M.D. 122 S. Centrest, Cumberland, Maryland | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| Burial | | 1/14/56 | | Hillcrest Burial Park | | Cumberland, Maryland | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| Jan 14, 1956 | | Winter R. Frantz, M.D. | | Charles L. George | | Cumberland, Md. | |

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

CERTIFICATE OF DEATH

NAME OF DECEASED: **JOHN THOMAS LAW**
 SEX: **MALE** AGE: **31** YEARS
 DATE OF BIRTH: **JANUARY 11, 1925**
 PLACE OF BIRTH: **WILMINGTON, DELAWARE**
 OCCUPATION: **SALES**
 MARITAL STATUS: **SINGLE**
 PLACE OF DEATH: **REYNOLDS HOSPITAL**
 DATE OF DEATH: **JANUARY 11, 1956**
 TIME OF DEATH: **10:30 AM**
 CAUSE OF DEATH: **MYOCARDIAL INFARCTION**
 MANNER OF DEATH: **NATURAL**

DR. NAME: **CHARLES E. LAW**
 DR. ADDRESS: **1000 N. W. 10th St., Miami, Fla.**
 DR. PHONE: **5-1234**
 DR. SIGNATURE: *[Signature]*

DR. NAME: **JOHN E. SWIFT**
 DR. ADDRESS: **1000 N. W. 10th St., Miami, Fla.**
 DR. PHONE: **5-1234**
 DR. SIGNATURE: *[Signature]*

DR. NAME: **JOHN E. SWIFT**
 DR. ADDRESS: **1000 N. W. 10th St., Miami, Fla.**
 DR. PHONE: **5-1234**
 DR. SIGNATURE: *[Signature]*

DR. NAME: **JOHN E. SWIFT**
 DR. ADDRESS: **1000 N. W. 10th St., Miami, Fla.**
 DR. PHONE: **5-1234**
 DR. SIGNATURE: *[Signature]*

DR. NAME: **JOHN E. SWIFT**
 DR. ADDRESS: **1000 N. W. 10th St., Miami, Fla.**
 DR. PHONE: **5-1234**
 DR. SIGNATURE: *[Signature]*

DR. NAME: **JOHN E. SWIFT**
 DR. ADDRESS: **1000 N. W. 10th St., Miami, Fla.**
 DR. PHONE: **5-1234**
 DR. SIGNATURE: *[Signature]*

DR. NAME: **JOHN E. SWIFT**
 DR. ADDRESS: **1000 N. W. 10th St., Miami, Fla.**
 DR. PHONE: **5-1234**
 DR. SIGNATURE: *[Signature]*

DR. NAME: **JOHN E. SWIFT**
 DR. ADDRESS: **1000 N. W. 10th St., Miami, Fla.**
 DR. PHONE: **5-1234**
 DR. SIGNATURE: *[Signature]*

DR. NAME: **JOHN E. SWIFT**
 DR. ADDRESS: **1000 N. W. 10th St., Miami, Fla.**
 DR. PHONE: **5-1234**
 DR. SIGNATURE: *[Signature]*

DR. NAME: **JOHN E. SWIFT**
 DR. ADDRESS: **1000 N. W. 10th St., Miami, Fla.**
 DR. PHONE: **5-1234**
 DR. SIGNATURE: *[Signature]*

DR. NAME: **JOHN E. SWIFT**
 DR. ADDRESS: **1000 N. W. 10th St., Miami, Fla.**
 DR. PHONE: **5-1234**
 DR. SIGNATURE: *[Signature]*

DR. NAME: **JOHN E. SWIFT**
 DR. ADDRESS: **1000 N. W. 10th St., Miami, Fla.**
 DR. PHONE: **5-1234**
 DR. SIGNATURE: *[Signature]*

BUREAU V. S.

JAN 17 1956

RECEIVED

00057

37
CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>ALLEGANY</u> | | STATE <u>MARYLAND</u> | | COUNTY <u>ALLEGANY</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland</u> | | LENGTH OF STAY (in this place)
<u>2 days</u> | | CITY (If outside corporate limits, write RURAL and give nearest town)
<u>Cresaptown</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS
<u>Sacred Heart Hospital</u> | | | | STREET ADDRESS (If rural give location)
<u>Near Rt. # 220</u> | | | |
| 3. NAME OF DECEASED (Type or Print)
<u>ELIZABETH LAVINA LEASE</u> | | | | 4. DATE OF DEATH
<u>1-2-56</u> | | | |
| 5. SEX
<u>Female</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
<u>Married</u> | | 8. DATE OF BIRTH
<u>March 4, 1902</u> | |
| 9. AGE last birthday
<u>53</u> yrs. | | 10. IF UNDER 1 YEAR
Months Days | | 11. IF UNDER 24 HRS.
Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own home</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Cresaptown, Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | | | | | | | |
| 13. FATHER'S NAME
<u>Jacob Leese</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Margaret Huff</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)
<u>No</u> | | | | 16. SOCIAL SECURITY NO.
<u>None</u> | | 17. INFORMANT & ADDRESS
<u>Mr. Marshall Lease Cresaptown, Md.</u> | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 587.0 IMMEDIATE CAUSE (A)
ANTECEDENT CAUSE(S) DUE TO (B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) | | | | <u>Acute Pancreatitis with Peritonitis</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 week</u> | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>12/31</u> , 19 <u>55</u> , to <u>1/2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/2</u> , 19 <u>56</u> , and that death occurred at <u>4:15</u> M., from the causes and on the date stated above. | | | | | | | |
| SIGNATURE
<u>C. M. Schindler</u> | | | | ADDRESS (Street, city, town, state)
<u>41 Green St. Cumberland, Md.</u> | | DATE SIGNED
<u>1/3/56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | | DATE THEREOF
<u>1/5/56</u> | | NAME OF CEMETERY OR CREMATORY
<u>Lease Cemetery</u> | | LOCATION (City, town, or county) (State)
<u>Cresaptown, Maryland</u> | |
| 24. REC'D BY REGISTRAR
<u>Jan. 4, 1956</u> | | REGISTRAR'S SIGNATURE
<u>Winter R. Frantz, M.D.</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE
<u>Charles L. George</u> | | ADDRESS
<u>Cumberland, Md.</u> | |

INSTRUCTIONS

1. **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED (Print or Write)

2. SEX

3. AGE

4. OCCUPATION

5. PLACE OF BIRTH

6. DATE OF DEATH

7. TIME OF DEATH

8. PLACE OF DEATH

9. CAUSE OF DEATH

10. MEDICAL EXAMINATION

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF CLERK

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF CORONER

18. SIGNATURE OF JURY

19. SIGNATURE OF JUDGE

BUREAU V. S.

JAN 6 1956

RECEIVED

INSTRUCTIONS

1. This certificate is to be filled out by the physician who attended the deceased or by the coroner if the death was sudden and unexpected. It is to be filled out in duplicate and the original is to be filed in the office of the Registrar of the Department of Health. The duplicate is to be filed in the office of the coroner if the death was sudden and unexpected. The certificate is to be filled out in duplicate and the original is to be filed in the office of the Registrar of the Department of Health. The duplicate is to be filed in the office of the coroner if the death was sudden and unexpected.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

| | | | | | |
|---|--------------------------------|---|--|--|--------------------------------------|
| 1. PLACE OF DEATH: | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | |
| COUNTY <u>Allegany</u> | | MARYLAND | STATE <u>Maryland</u> COUNTY <u>Allegany</u> | | |
| CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN <u>Cumberland</u> | | LENGTH OF STAY (in this place) | CITY (If outside corporate limits write RURAL and give nearest town)
OR TOWN <u>Rural) Cumberland</u> | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Highway, Route 40- about 500 feet east of cement Bridge, Narrows Route 6</u> | | | STREET ADDRESS (If rural, give location) | | |
| 3. NAME OF DECEASED: (First) <u>George</u> | | (Middle) <u>Joseph</u> | (Last) <u>Leyh</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 3 19 56</u> | |
| 5. SEX: <u>male</u> | 6. COLOR OR RACE: <u>white</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | 8. DATE OF BIRTH: <u>Sept. 30-1894</u> | | 9. AGE last birthday: <u>61</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Warehouse man</u> | | 10b. KIND OF BUSINESS OR INDUSTRY: <u>Standard Oil Co.</u> | | 11. BIRTHPLACE (State or foreign country): <u>Baltimore, Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | 13. FATHER'S NAME: <u>Fredrick Leyh</u> | | |
| 14. MOTHER'S MAIDEN NAME: <u>Emma Beckwith</u> | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>1917-16 weeks.</u> | | |
| 16. SOCIAL SECURITY No.: <u>214-05-5987</u> | | | 17. INFORMANT & ADDRESS: <u>Route #6 Narrows (wife) Irene H. Leyh, Cumberland, Md.</u> | | |

| | | | | | |
|--|---|---|---|--|---|
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| Immediate cause <u>(a) Intracranial hemorrhage due to a fractured skull (frontal) Fracture of upper and lower maxillary, fractured larynx also had lacerations</u>
Antecedent cause(s) <u>(b) Hit by a People's Transit Lines Bus. Inc.</u>
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last <u>(c) Hit by a People's Transit Lines Bus. Inc.</u> | | | sudden | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | |
| 19a. DATE OF OPERATION: | | 19b. MAJOR FINDING OF OPERATION: | | | 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Highway #40</u> | 21c. (City or town) (County) (State) <u>Cumberland Allegany Md.</u> | | | |
| 21d. TIME (Month) (Day) (Year) <u>Jan. 3-1955 P.M.</u> | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 21f. HOW DID INJURY OCCUR? <u>Walking, went to cross road and was hit by a bus.</u> | | | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | |
| SIGNATURE <u>H.V. Deming M.D.</u> <u>H.V. Deming M.D.</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>1-3-1956</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u> | DATE THEREOF <u>Jan. 6, 1956</u> | NAME OF CEMETERY OR CREMATORY <u>Maple Grove Cemetery</u> | LOCATION (City, town, or county) (State) <u>Taichance, Pennsylvania</u> | | |
| DATE REC'D BY LOCAL REG. <u>Jan. 5, 1956</u> | REGISTRAR'S SIGNATURE <u>Antes R. Bratz, M.D.</u> | 24. FUNERAL DIRECTOR <u>William H. Light, Cumberland, Maryland</u> | | | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 9 1956
BUREAU V. S.

39

CERTIFICATE OF DEATH

00059

Reg. Dist. No.

1. PLACE OF DEATH

COUNTY Allegany
CITY (If outside corporate limits, write RURAL
OR and give nearest town)
TOWN CumberlandMARYLAND
LENGTH OF STAY
(in this place)
50 yearsHOSPITAL OR
INSTITUTION OR
STREET ADDRESS
210 Knox Street

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN CumberlandSTREET
ADDRESS
210 Knox Street3. NAME OF
DECEASED
(Type or Print)

(First)

(Middle)

(Last)

CHARLESMILTONMARKS4. DATE
OF
DEATH

(Month)

(Day)

(Year)

Jan. 6,19 56

5. SEX

6. COLOR OR
RACE7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)

8. DATE OF BIRTH

9. AGE last birthday

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

MaleWhiteMarriedOct. 6, 188570

yrs.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)
Electrician10b. KIND OF BUSINESS
OR INDUSTRY
Rayon Industry11. BIRTHPLACE (State or foreign country)
Pennsylvania12. CITIZEN OF WHAT
COUNTRY?
USA

13. FATHER'S NAME

Franklin Marks

14. MOTHER'S MAIDEN NAME

Sarah Ann Witherson15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of service)
no16. SOCIAL SECURITY NO.
217-10-538717. INFORMANT & ADDRESS
Mrs. C. M. Marks, Cumberland, Md.

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

18. MEDICAL CERTIFICATION

INTERVAL BETWEEN
ONSET AND DEATHIMMEDIATE CAUSE (A) Coronary Occlusion
ANTECEDENT CAUSE(S) DUE TO
DISEASES OR CONDITIONS, IF ANY,
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST. DUE TO
(B) Coronary Heart Disease
(C)1 day2 yearsII OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
or INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
While ☐ Not while ☐
at work at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 5, 1955, to Jan 6, 1956, that I last saw the deceased
alive on Jan. 6, 1956, and that death occurred at M, from the causes and on the date stated above.

SIGNATURE

Ray L. Boenig62 Greene St. M. Cumberland, Md.

ADDRESS (Street, city, town, state)

1-6-56

DATE SIGNED

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)
Burial

DATE THEREOF

Jan 9 1956

NAME OF CEMETERY OR CREMATORY

Hill Crest Cemetery

LOCATION (City, town, or county)

Cumberland, Md.

(State)

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

Jan. 9, 1956Walter R. Hantz, M.D.

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

William H. Kight, Cumberland, Md.

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

ENCLOSURE

RECEIVED
JAN 11 1956
BUREAU V. 2

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 19

REG. NO. 111

1. DEATH INFORMATION

2. PLACE OF DEATH

3. CAUSE OF DEATH

4. MANNER OF DEATH

5. PLACE OF BIRTH

6. DATE OF BIRTH

7. SEX

8. RACE

9. AGE

10. OCCUPATION

11. MARITAL STATUS

12. EDUCATION

13. RELIGION

14. SOCIAL CLASS

15. PREVIOUS ILLNESS

16. PREVIOUS SURGERY

17. PREVIOUS TRAUMA

18. PREVIOUS DRUGS

19. PREVIOUS ALCOHOL

20. PREVIOUS TOBACCO

21. PREVIOUS OTHER

22. PREVIOUS OTHER

23. PREVIOUS OTHER

24. PREVIOUS OTHER

25. PREVIOUS OTHER

26. PREVIOUS OTHER

27. PREVIOUS OTHER

28. PREVIOUS OTHER

29. PREVIOUS OTHER

30. PREVIOUS OTHER

31. PREVIOUS OTHER

32. PREVIOUS OTHER

33. PREVIOUS OTHER

34. PREVIOUS OTHER

35. PREVIOUS OTHER

36. PREVIOUS OTHER

37. PREVIOUS OTHER

38. PREVIOUS OTHER

39. PREVIOUS OTHER

40. PREVIOUS OTHER

41. PREVIOUS OTHER

42. PREVIOUS OTHER

43. PREVIOUS OTHER

44. PREVIOUS OTHER

45. PREVIOUS OTHER

46. PREVIOUS OTHER

47. PREVIOUS OTHER

48. PREVIOUS OTHER

49. PREVIOUS OTHER

50. PREVIOUS OTHER

51. PREVIOUS OTHER

52. PREVIOUS OTHER

53. PREVIOUS OTHER

54. PREVIOUS OTHER

55. PREVIOUS OTHER

56. PREVIOUS OTHER

57. PREVIOUS OTHER

58. PREVIOUS OTHER

59. PREVIOUS OTHER

60. PREVIOUS OTHER

61. PREVIOUS OTHER

62. PREVIOUS OTHER

63. PREVIOUS OTHER

64. PREVIOUS OTHER

65. PREVIOUS OTHER

66. PREVIOUS OTHER

67. PREVIOUS OTHER

68. PREVIOUS OTHER

69. PREVIOUS OTHER

70. PREVIOUS OTHER

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00060

97 -

CERTIFICATE OF DEATH

Reg. Dist. No. 8

Item 9 Film G191 1-20-56 et

| | | | | | | | |
|---|----------------------------------|---|--|--|--|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>MD.</u> | | COUNTY <u>Allegany</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town)
<u>Lonaconing</u> | | LENGTH OF STAY (in this place)
<u>82yrs.</u> | | CITY (If outside corporate limits, write RURAL and give nearest town)
<u>Lonaconing</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS
<u>East Main Street</u> | | | | STREET ADDRESS (If rural give location)
<u>East Main Street</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <u>DAVID</u> (Middle) <u>--</u> (Last) <u>McALPINE</u> | | | | (Month) <u>Jan</u> (Day) <u>9</u> (Year) <u>1956</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
<u>Single</u> | 8. DATE OF BIRTH
<u>Sept, 6th. 1874</u> | 9. AGE last birthday
<u>82</u> yrs. | IF UNDER 1 YEAR
Months <u>89</u> Days <u>81</u> | | IF UNDER 24 HRS.
Hours <u>19</u> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired--Celanese Plant.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Lonaconing</u> | | 11. BIRTHPLACE (State or foreign country)
<u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>John McAlpine</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Elizabeth Flemming</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>220-10-9321</u> | | 17. INFORMANT & ADDRESS
<u>Mrs. Frederick Butts, (Sister)</u> | | | |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| 332X IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u> | | | | <u>Wilkesbarra, PA.</u> | | <u>Thes</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral Arteriosclerosis</u> | | | | | | <u>2-3 years</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>52</u> , to <u>Jan</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 8</u> , 19 <u>56</u> , and that death occurred at <u>8 AM</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE
<u>George Richards</u> | | M.D. <u>Lonaconing</u> | | ADDRESS (Street, city, town, state)
<u>1-10 St</u> | | DATE SIGNED | |
| 23. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | DATE THEREOF
<u>Jan. 11, 1956</u> | | NAME OF CEMETERY OR CREMATORY
<u>Oak Hill Cemetery</u> | | LOCATION (City, town, or county) (State)
<u>Lonaconing, MD.</u> | |
| 24. REC'D BY REGISTRAR
<u>Janette M Boal</u> | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE
<u>George E</u> | | ADDRESS
<u>Lonaconing, MD.</u> | |
| DATE <u>1-11-56</u> | | | | | | | |

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 455 10M

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | | |
|---|------------------|--|--|--|--|---|------------------------------------|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | | |
| COUNTY Allegany | | MARYLAND | | STATE Maryland | | COUNTY Allegany | | |
| CITY (If outside corporate limits, write RURAL or and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | | |
| TOWN Cumberland, | | | | TOWN Cumberland, | | 02 | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS 219 Wallace St., | | | | STREET ADDRESS (If rural give location) 219 Wallace St., | | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | | |
| (First) CHRISTOPHER (Middle) RUDIGIL (Last) McCULLOUGH | | | | (Month) Jan. (Day) 13, (Year) 19 56 | | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | | IF UNDER 24 HRS. |
| Male | White | Single | June 12, 1877 | 78 yrs. | Months | Days | Hours | Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Pipefitter | | | 10b. KIND OF BUSINESS OR INDUSTRY B. & O. Rwy. | | 11. BIRTHPLACE (State or foreign country) Cumberland, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. | |
| 13. FATHER'S NAME Christopher McCullough | | | | 14. MOTHER'S MAIDEN NAME Anna V. Coleman | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No, | | 16. SOCIAL SECURITY NO. 705-09-9832 | | 17. INFORMANT & ADDRESS Miss Margaret McCullough 219 Wallace St. Cumberland, Md. | | | | |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | | |
| 442X IMMEDIATE CAUSE (A) Hypertension, Cardiac Vascular | | | | INTERVAL BETWEEN ONSET AND DEATH 6'30'54 | | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) Renal disease (uremia) | | | | to | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | death | | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | | |
| 22. I hereby certify that I attended the deceased from 6:30, 19 54, to 1-13-19 56, that I last saw the deceased alive on 12-17-55, and that death occurred at 7:46 P.M. from the causes and on the date stated above. | | | | | | | | |
| SIGNATURE J. F. Williams M.D. | | | | ADDRESS (Street, city, town, state) Cumberland, Md. | | DATE SIGNED 1-14-56 | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | DATE THEREOF 1/15/56 | | NAME OF CEMETERY OR CREMATORY Rose Hill Cem. | | LOCATION (City, town, or county) Cumberland, Maryland (State) | | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | | |
| DATE 1-15-1956 | | Walter R. Frantz, M.D. | | H. Wayne George | | Cumberland, Md. | | |

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

200700721

1. The death of a person, whether or not a citizen of the United States, shall be reported to the nearest health officer of the State or Territory in which the death occurred, and to the nearest health officer of the country in which the death occurred, if the death occurred in a foreign country. The health officer shall file a report of the death with the nearest health officer of the State or Territory in which the death occurred, and with the nearest health officer of the country in which the death occurred, if the death occurred in a foreign country. The health officer shall also file a report of the death with the nearest health officer of the State or Territory in which the death occurred, and with the nearest health officer of the country in which the death occurred, if the death occurred in a foreign country.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

00000

1. DRUGS AND MEDICINE PRESCRIBED OR ADMINISTERED

2. PLACE OF DEATH

3. CAUSE OF DEATH

4. MANNER OF DEATH

5. TIME OF DEATH

6. DATE OF DEATH

7. SIGNATURE OF DEATH OFFICER

8. SIGNATURE OF WITNESS

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF CORONER

11. SIGNATURE OF JURY

12. SIGNATURE OF JUDGE

13. SIGNATURE OF CLERK

14. SIGNATURE OF SHERIFF

15. SIGNATURE OF DEPUTY SHERIFF

16. SIGNATURE OF CONSTABLE

17. SIGNATURE OF JAILER

18. SIGNATURE OF PRISONER

BUREAU V. 2

JAN 17 1956

RECEIVED

41

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|---|------------------|--|-----------------------------------|---|---|--|------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY ALLEGANY | | MARYLAND | | STATE MARYLAND | | COUNTY ALLEGANY | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN CUMBERLAND | | 8 DAYS | | TOWN CUMBERLAND | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL | | | | STREET ADDRESS 64 GREENE STREET | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) MARIE | | (Middle) C. | | (Last) MC GINN | | (Month) JANUARY 30, 19 56 | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| FEMALE | WHITE | MARRIED | JUNE 5, 1886 | 69 yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| Housewife | | | Own home | | Keyser, WEST VIRGINIA | | U. S. A. |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| CHARLES CRAWFORD | | | | LOUISE MILLER | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| no, | | None | | MEMORIAL HOSPITAL
MEMORIAL AND WARWICK AVES. | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 422. IMMEDIATE CAUSE (A) Arteriosclerotic Cardiovascular disease | | | | | | 9 years | |
| ANTECEDENT CAUSE(S) DUE TO (B) disease | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. See advanced coronary artery disease | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) | | (County) (State) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from 3:27, 19 47, to 1:30, 19 56, that I last saw the deceased alive on 1:30, 19 56, and that death occurred at 6:26 P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE Wm. F. Williams | | | | ADDRESS (Street, city, town, state) Cumberland MD | | DATE SIGNED 1-31-56 | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) | |
| Burial | | 2/2/56 | | Hillcrest Burial Park | | Cumberland, Maryland | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| Feb. 2, 1956 | | Walter R. Frank, M.D. | | H. Wayne George | | Cumberland, Maryland | |

INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

CERTIFICATE OF DEATH

MASSACHUSETTS

DEPARTMENT OF HEALTH - BOSTON

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

BUREAU V. S.

FEB 6 1956

RECEIVED

Mr. & Mrs. Williams

MASSACHUSETTS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

98
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00063

Reg. Dist.

No. 6

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Md.</u> | | COUNTY <u>Allegany</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)
<u>TOWN Rural) Barton</u> | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits write RURAL and give nearest town)
OR
TOWN <u>Barton</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>In Baker Coal Co's Mine. D.O.A. at Memorial Hospital</u> | | | | STREET ADDRESS (If rural, give location)
<u>1</u> | | | |
| 3. NAME OF DECEASED:
(Type or Print) (First) (Middle) (Last)
<u>Louis Milton Michael</u> | | | | 4. DATE OF DEATH
(Month) (Day) (Year)
<u>Jan. 9 19 56</u> | | | |
| 5. SEX:
<u>male</u> | 6. COLOR OR RACE:
<u>white</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):
<u>married</u> | 8. DATE OF BIRTH:
<u>May 29-1918</u> | 9. AGE last birthday:
<u>37</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):
<u>Coal Miner</u> | | 10b. KIND OF BUSINESS OR INDUSTRY:
<u>Mining coal</u> | | 11. BIRTHPLACE (State or foreign country):
<u>Bond, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME:
<u>Addis Michael</u> | | | | 14. MOTHER'S MAIDEN NAME:
<u>Bessie Fazenbaker</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.)
<u>Yes</u> | | 16. SOCIAL SECURITY No.:
<u>213-10-7613</u> | | 17. INFORMANT & ADDRESS:
<u>(wife) Emily Trenum Michael, Barton, Md.</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | | | | | |
| <u>420.1</u>
Immediate cause (a) <u>Coronary occlusion (left)</u>
DUE TO
Antecedent cause(s) (b) <u>Atherosclerosis</u>
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) | | | | | | | <u>sudden</u> |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION: | | | | 19b. MAJOR FINDING OF OPERATION: | | | 20. AUTOPSY?
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY | | 21c. (City or town) (County) (State) | | | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21e. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.
SIGNATURE <u>H.V. Deming M.D.</u> <u>H.V. Deming M.D.</u> M.D. <u>CHIEF MEDICAL EXAMINER</u> <u>DATE SIGNED</u>
<u>H.V. Deming M.D.</u> <u>DEPUTY MEDICAL EXAMINER</u> <u>*Jan. 9-1956</u>
<u>H.V. Deming M.D.</u> <u>ASSISTANT MEDICAL EXAM.</u> | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify):
<u>Burial</u> | | DATE THEREOF
<u>1/12/56</u> | | NAME OF CEMETERY OR CREMATORY
<u>St. Peter's</u> | | LOCATION (City, town, or county) (State)
<u>Bloomington Md</u> | |
| DATE REC'D BY LOCAL REG.
<u>1-11-56</u> | | REGISTRAR'S SIGNATURE
<u>Miss Jean C Kelly</u> | | 24. FUNERAL DIRECTOR
<u>E. J. Boral</u> | | ADDRESS | |

BUREAU V. S.

RECEIVED
JAN 10 1950

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00064

42

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|---|-------------------------|---|--|---|------------------------|--|-------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY Allegany | | MARYLAND | | STATE Maryland | | COUNTY Allegany | |
| CITY (If outside corporate limits, write RURAL or and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | OR | |
| TOWN Cumberland | | Oct. 1947 | | TOWN Westernport | | 43 | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| (First) Frederick (Middle) Aubrey (Last) Miller | | | | January 28 19 56 | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| Male | White | Single | June 14, 1880 | 75 yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None - Invalid since 11 years of age | | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| | | | | Maryland, Westernport | | U. S. A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| John D. Miller | | | | Mary S. Duckworth | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| No | | None | | Allegany County Infirmary Records | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| 422.2 IMMEDIATE CAUSE (A) Chronic Myocarditis | | | | | | ? | |
| ANTECEDENT CAUSE(S) DUE TO (B) Cerebral Arteriosclerosis | | | | | | ? | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Spastic Arthritis | | | | | | ? | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic Nephritis | | | | | | ? | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from Jan. 28, 1956, to Jan. 28, 1956, that I last saw the deceased alive on Jan. 28, 1956, and that death occurred at 11:59 P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE James E. McLean, M.D. | | | | ADDRESS (Street, city, town, state) 49 Green St. | | DATE SIGNED 1-30-56 | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| Burial | | Jan. 31, 1956 | | Philos Cemetery | | Westernport, Maryland. | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| Jan. 31, 1956 | | Walter R. Feantz, M.D. | | Boal Funeral Home, Westernport, Maryland. | | | |

CERTIFICATE OF DEATH

See Back

ATTEST: I hereby certify that the foregoing is a true and correct copy of the original as filed in my office.

Signature of Registrar
 Date of Death
 Place of Death

Signature of Physician
 Date of Death
 Place of Death

Signature of Informant

Signature of Informant

Signature of Informant

Signature of Informant

Signature of Informant

Signature of Informant

Signature of Informant

Signature of Informant

Signature of Informant

Signature of Informant

Signature of Informant

Signature of Informant

Signature of Informant

Signature of Informant

Signature of Informant

Signature of Informant

Signature of Informant

Signature of Informant

BUREAU V. S.

FEB 2 1956

RECEIVED

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1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

| | | | | | |
|---|---|---|---|--|---|
| LIMITS
Dr. Ballin | | MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 | | 00065 | |
| 43 | | Reg. Dist. No. 4 | | | |
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> MARYLAND | | STATE <u>Maryland</u> COUNTY <u>Allegany</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN <u>Cumberland</u> | | CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN <u>Cumberland</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS
<u>Memorial Hospital</u> | | STREET ADDRESS (If rural give location)
<u>10 Smith Street</u> | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last)
<u>George Albert Moulton</u> | | | 4. DATE OF DEATH (Month) (Day) (Year)
<u>1 - 22 - 19 56</u> | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
<u>Married</u> | 8. DATE OF BIRTH
<u>April 6, 1892</u> | 9. AGE last birthday
<u>63</u> yrs. | IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.) |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Estimator - Hazelwood Construction Company</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Denmark, Maine</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> |
| 13. FATHER'S NAME
<u>George Moulton</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Clara Bennett</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>229-24-9976</u> | | 17. INFORMANT & ADDRESS
<u>Memorial Hospital</u> | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (A)
<u>527.1 Cor pulmonale</u> | | | | | <u>6 mos</u> |
| ANTECEDENT CAUSE(S) DUE TO (B)
<u>Ewing's sarcoma</u> | | | | | <u>12 years</u> |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <u>9-4</u> , 19 <u>53</u> , to <u>1-22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-22</u> , 19 <u>56</u> , and that death occurred at <u>5:25 P.</u> M, from the causes and on the date stated above. | | | | | |
| SIGNATURE
<u>Raya W. Ballin</u> | | DATE SIGNED
<u>M.D. 62 Greene St Cumberland</u> | | DATE SIGNED
<u>1-22-56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | | DATE THEREOF
<u>Jan. 25, 1956</u> | | NAME OF CEMETERY OR CREMATORY
<u>Hillcrest Burial Park</u> | |
| 24. REC'D BY REGISTRAR
<u>Jan. 24, 1956</u> | | REGISTRAR'S SIGNATURE
<u>Walter R. Frantz, M.D.</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE
<u>Charles L. George, Cumberland, Maryland.</u> | |

RECEIVED

RECEIVED
JAN 25 1956
BUREAU A. S.

CERTIFICATE OF DEATH

U.S. DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

100002

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. PLACE OF DEATH

10. DATE OF DEATH

11. SIGNATURE OF DECEASED

12. SIGNATURE OF WITNESS

13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF CLERK

15. SIGNATURE OF JUDGE

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF CORONER

18. SIGNATURE OF JURY

19. SIGNATURE OF COURT

20. SIGNATURE OF STATE

21. SIGNATURE OF NATION

22. SIGNATURE OF WORLD

23. SIGNATURE OF UNIVERSE

24. SIGNATURE OF GOD

25. SIGNATURE OF HEAVEN

26. SIGNATURE OF EARTH

27. SIGNATURE OF WATER

28. SIGNATURE OF FIRE

29. SIGNATURE OF AIR

30. SIGNATURE OF LIGHT

31. SIGNATURE OF DARKNESS

32. SIGNATURE OF LIFE

33. SIGNATURE OF DEATH

34. SIGNATURE OF REBIRTH

35. SIGNATURE OF RESURRECTION

36. SIGNATURE OF JUDGMENT

37. SIGNATURE OF GLORY

38. SIGNATURE OF HONOR

39. SIGNATURE OF POWER

40. SIGNATURE OF WEALTH

41. SIGNATURE OF KNOWLEDGE

42. SIGNATURE OF WISDOM

43. SIGNATURE OF FAITH

44. SIGNATURE OF HOPE

45. SIGNATURE OF CHARITY

46. SIGNATURE OF LOVE

47. SIGNATURE OF MERCY

48. SIGNATURE OF GRACE

49. SIGNATURE OF PEACE

50. SIGNATURE OF JOY

51. SIGNATURE OF SORROW

52. SIGNATURE OF GRIEF

53. SIGNATURE OF PAIN

54. SIGNATURE OF SUFFERING

55. SIGNATURE OF TRIAL

56. SIGNATURE OF TEST

57. SIGNATURE OF PROOF

58. SIGNATURE OF EVIDENCE

59. SIGNATURE OF FACT

60. SIGNATURE OF TRUTH

61. SIGNATURE OF REALITY

62. SIGNATURE OF EXISTENCE

63. SIGNATURE OF BEING

64. SIGNATURE OF HAVE

65. SIGNATURE OF DO

66. SIGNATURE OF KNOW

67. SIGNATURE OF UNDERSTAND

68. SIGNATURE OF BELIEVE

69. SIGNATURE OF TRUST

70. SIGNATURE OF OBEY

71. SIGNATURE OF RESPECT

72. SIGNATURE OF HONOR

73. SIGNATURE OF GLORY

74. SIGNATURE OF POWER

75. SIGNATURE OF WEALTH

76. SIGNATURE OF KNOWLEDGE

77. SIGNATURE OF WISDOM

78. SIGNATURE OF FAITH

79. SIGNATURE OF HOPE

80. SIGNATURE OF CHARITY

81. SIGNATURE OF LOVE

82. SIGNATURE OF MERCY

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84. SIGNATURE OF PEACE

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87. SIGNATURE OF GRIEF

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89. SIGNATURE OF SUFFERING

90. SIGNATURE OF TRIAL

91. SIGNATURE OF TEST

92. SIGNATURE OF PROOF

93. SIGNATURE OF EVIDENCE

94. SIGNATURE OF FACT

95. SIGNATURE OF TRUTH

96. SIGNATURE OF REALITY

97. SIGNATURE OF EXISTENCE

98. SIGNATURE OF BEING

99. SIGNATURE OF HAVE

100. SIGNATURE OF DO

101. SIGNATURE OF KNOW

102. SIGNATURE OF UNDERSTAND

103. SIGNATURE OF BELIEVE

104. SIGNATURE OF TRUST

105. SIGNATURE OF OBEY

106. SIGNATURE OF RESPECT

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113. SIGNATURE OF FAITH

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116. SIGNATURE OF LOVE

117. SIGNATURE OF MERCY

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140. SIGNATURE OF OBEY

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144. SIGNATURE OF POWER

145. SIGNATURE OF WEALTH

146. SIGNATURE OF KNOWLEDGE

147. SIGNATURE OF WISDOM

148. SIGNATURE OF FAITH

149. SIGNATURE OF HOPE

150. SIGNATURE OF CHARITY

151. SIGNATURE OF LOVE

152. SIGNATURE OF MERCY

153. SIGNATURE OF GRACE

154. SIGNATURE OF PEACE

155. SIGNATURE OF JOY

156. SIGNATURE OF SORROW

157. SIGNATURE OF GRIEF

158. SIGNATURE OF PAIN

159. SIGNATURE OF SUFFERING

160. SIGNATURE OF TRIAL

161. SIGNATURE OF TEST

162. SIGNATURE OF PROOF

163. SIGNATURE OF EVIDENCE

164. SIGNATURE OF FACT

165. SIGNATURE OF TRUTH

166. SIGNATURE OF REALITY

167. SIGNATURE OF EXISTENCE

168. SIGNATURE OF BEING

169. SIGNATURE OF HAVE

170. SIGNATURE OF DO

171. SIGNATURE OF KNOW

172. SIGNATURE OF UNDERSTAND

173. SIGNATURE OF BELIEVE

174. SIGNATURE OF TRUST

175. SIGNATURE OF OBEY

176. SIGNATURE OF RESPECT

177. SIGNATURE OF HONOR

178. SIGNATURE OF GLORY

179. SIGNATURE OF POWER

180. SIGNATURE OF WEALTH

181. SIGNATURE OF KNOWLEDGE

182. SIGNATURE OF WISDOM

183. SIGNATURE OF FAITH

184. SIGNATURE OF HOPE

185. SIGNATURE OF CHARITY

186. SIGNATURE OF LOVE

187. SIGNATURE OF MERCY

188. SIGNATURE OF GRACE

189. SIGNATURE OF PEACE

190. SIGNATURE OF JOY

191. SIGNATURE OF SORROW

192. SIGNATURE OF GRIEF

193. SIGNATURE OF PAIN

194. SIGNATURE OF SUFFERING

195. SIGNATURE OF TRIAL

196. SIGNATURE OF TEST

197. SIGNATURE OF PROOF

198. SIGNATURE OF EVIDENCE

199. SIGNATURE OF FACT

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201. SIGNATURE OF REALITY

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204. SIGNATURE OF HAVE

205. SIGNATURE OF DO

206. SIGNATURE OF KNOW

207. SIGNATURE OF UNDERSTAND

208. SIGNATURE OF BELIEVE

209. SIGNATURE OF TRUST

210. SIGNATURE OF OBEY

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216. SIGNATURE OF KNOWLEDGE

217. SIGNATURE OF WISDOM

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243. SIGNATURE OF BELIEVE

244. SIGNATURE OF TRUST

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275. SIGNATURE OF DO

276. SIGNATURE OF KNOW

277. SIGNATURE OF UNDERSTAND

278. SIGNATURE OF BELIEVE

279. SIGNATURE OF TRUST

280. SIGNATURE OF OBEY

281. SIGNATURE OF RESPECT

282. SIGNATURE OF HONOR

44
CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH

COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN Cumberland LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS 538 Maryland Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN CumberlandSTREET ADDRESS (If rural give location)
538 Maryland Avenue

3. NAME OF DECEASED (Type or Print)

(First) CATHERINE (Middle) HELEN (Last) MULLEN

4. DATE OF DEATH

(Month) (Day) (Year)
January 14 19 56

5. SEX

Female

6. COLOR OR RACE
White7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
Married8. DATE OF BIRTH
Oct. 13, 19029. AGE last birthday
53 yrs.IF UNDER 1 YEAR
Months DaysIF UNDER 24 HRS.
Hours Min.10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife10b. KIND OF BUSINESS OR INDUSTRY
Ownhome11. BIRTHPLACE (State or foreign country)
Franklin, Maryland12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

WILLIAM COLLINS

14. MOTHER'S MAIDEN NAME

ELLA CAREY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.
214-05-889517. INFORMANT & ADDRESS 538 Md. Ave.
Michael E. Mullen Cumberland, Md.

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
IMMEDIATE CAUSE (A)
ANTECEDENT CAUSE(S) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST. DUE TO
(C)

18. MEDICAL CERTIFICATION

acute coronary occlusion

INTERVAL BETWEEN ONSET AND DEATH

1/2 hour

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-3-1952, to 1-14-1956, that I last saw the deceased alive on 1-13-1956, and that death occurred at 6 A.M. from the causes and on the date stated above.

SIGNATURE

ADDRESS (Street, city, town, state)

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

1/17/1956

Winter R. Frantz, M.D.

John J. Hafer, Cumberland, Maryland

INSTRUCTIONS

1. **WITHIN CORPORATE LIMITS**

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---------------------|--|--------|--|--------|--|---------|--|-------------------|--|------------------|--|-------------------|--|------------------|--|------------------|--|--------------------|--|---------------------|--|---------------------------|--|----------------------------|--|----------------------------|--|--------------------------|--|-----------------------|--|------------------------|--|------------------------|--|----------------------------|--|----------------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. RACE | | 5. PLACE OF BIRTH | | 6. DATE OF BIRTH | | 7. PLACE OF DEATH | | 8. DATE OF DEATH | | 9. TIME OF DEATH | | 10. CAUSE OF DEATH | | 11. MANNER OF DEATH | | 12. SIGNATURE OF DECEASED | | 13. SIGNATURE OF WITNESSES | | 14. SIGNATURE OF PHYSICIAN | | 15. SIGNATURE OF CORONER | | 16. SIGNATURE OF JURY | | 17. SIGNATURE OF JUDGE | | 18. SIGNATURE OF CLERK | | 19. SIGNATURE OF REGISTRAR | | 20. SIGNATURE OF OTHER OFFICIALS | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

MASSACHUSETTS
 DEPARTMENT OF HEALTH
 BUREAU OF VITAL RECORDS
 100 STATE STREET, ROOM 100
 BOSTON, MASSACHUSETTS 02109
 TELEPHONE 522-1234
 FAX 522-1235
 HOURS: 9:00 AM - 5:00 PM
 MONDAY - FRIDAY
 10:00 AM - 4:00 PM
 SATURDAY
 10:00 AM - 4:00 PM
 SUNDAY
 10:00 AM - 4:00 PM

BUREAU V. S.

JAN 18 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

81

CERTIFICATE OF DEATH

00067

Reg. Dist. No. 9

| | | | | | | | |
|---|---|--|---|--|---|--|---|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>MD.</u> | | COUNTY <u>Allegany</u> | |
| CITY (If outside corporate limits, write RURAL or end give nearest town)
<u>22 Frostburg</u> | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town)
<u>Lonaconing</u> | | TOWN <u>X</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS
<u>Miners Hospital</u> | | | | STREET ADDRESS (If rural give location)
<u>West Main Street</u> | | | |
| 3. NAME OF DECEASED
(Type or Print) <u>DAVID</u> (First) <u>M.</u> (Middle) <u>MURPHY</u> (Last) | | | | 4. DATE OF DEATH
(Month) <u>Jan.</u> (Day) <u>28th.</u> (Year) <u>19 56</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
<u>Married</u> | 8. DATE OF BIRTH
<u>May 1st. 1879</u> | 9. AGE last birthday
<u>76</u> yrs. | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired Miner</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Coal Mine</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Lonaconing, MD.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>William Murphy</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Janet McIntyre</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>NONE</u> | | 17. INFORMANT & ADDRESS
<u>Myrtle Murphy (WIFE)</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
<u>331X</u> | | | | 18. MEDICAL CERTIFICATION
<u>Lonaconing, MD.</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>4 days</u> | |
| IMMEDIATE CAUSE (A)
<u>Cerebral Vascular Accident</u> | | | | ANTECEDENT CAUSE(S) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST.
(B)
<u>Essential hypertension</u> | | <u>several years</u> | |
| | | | | (C)
<u>Arteriosclerosis</u> | | <u>several years</u> | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>1-26</u> , 19 <u>56</u> , to <u>1-28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-28-56</u> , 19 <u> </u> , and that death occurred <u>3:30 PM</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE
<u>Leslie R. Miller</u> | | | | ADDRESS (Street, city, town, state)
<u>M. D. Lonaconing, Md.</u> | | DATE SIGNED
<u>1-30-56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | | DATE THEREOF
<u>Jan. 31. 1956</u> | | NAME OF CEMETERY OR CREMATORY
<u>Memorial Park</u> | | LOCATION (City, town, or county) (State)
<u>Frostburg, MD.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE
<u>Wm. Harry A. Roe</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE
<u>GEORGE EICHORN, LONACONING, MD.</u> | | | |
| DATE
<u>2-2-56</u> | | | | | | | |

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BOSTON

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

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TIME OF DEATH

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EDUCATION

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

BUREAU V. S.

FEB 6 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 6

82

| | | | | | | | |
|---|----------------------------------|--|--|--|--|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Md.</u> | | COUNTY <u>Allegany</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN <u>Westernport</u> | | LENGTH OF STAY (In this place)
<u>1 mo.</u> | | CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN <u>Pekin</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Kookon Nursing Home</u> | | | | STREET ADDRESS (If rural give location)
<u>X</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <u>James</u> (Middle) <u>Herbert</u> (Last) <u>Myers</u> | | | | (Month) <u>Jan.</u> (Day) <u>5</u> (Year) <u>1956</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | 8. DATE OF BIRTH
<u>17 Dec 1885</u> | 9. AGE last birthday
<u>70</u> yrs. | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miner</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Coal Mine</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Barton, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Lewis Myers</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Evelyn Connors</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> | | 16. SOCIAL SECURITY NO.
<u>220-03-7971A</u> | | 17. INFORMANT & ADDRESS
<u>Janie Myers Lee, Pekin, Md.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 420.0 IMMEDIATE CAUSE (A) <u>Arteriosclerotic heart disease</u> | | | | | | <u>several years</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arteriosclerosis</u> | | | | | | <u>undetermined</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u> </u> | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u> </u> <u> </u> <u> </u> <u> </u> | | 21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Dec 20, 1955</u> , to <u>Jan 5, 1956</u> , that I last saw the deceased alive on <u>Jan 5, 1956</u> , and that death occurred at <u>4:23</u> P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE
<u>James McWhorter Jr</u> | | M.D.
<u>Piedmont</u> | | ADDRESS (Street, city, town, state)
<u>W. Va 1-6-56</u> | | DATE SIGNED
<u>1-6-56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | DATE THEREOF
<u>1/8/56</u> | | NAME OF CEMETERY OR CREMATORY
<u>Laurel Hill</u> | | LOCATION (City, town, or county) (State)
<u>Moscow Md.</u> | |
| 24. REC'D BY REGISTRAR
DATE <u>1-6-56</u> | | REGISTRAR'S SIGNATURE
<u>Mrs Joan C Kelly</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE
<u>E J Boral</u> | | ADDRESS
<u>Westernport, Md.</u> | |

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

CERTIFICATE OF DEATH

STATE OF NEW YORK DEPARTMENT OF HEALTH-BUREAU OF VITAL STATISTICS

100-000

SHORT STATEMENT

1. Name of deceased: [illegible]
 2. Sex: [illegible]
 3. Age: [illegible]
 4. Date of birth: [illegible]
 5. Date of death: [illegible]
 6. Place of death: [illegible]
 7. Cause of death: [illegible]
 8. Manner of death: [illegible]
 9. Occupation: [illegible]
 10. Education: [illegible]
 11. Marital status: [illegible]
 12. Name of informant: [illegible]
 13. Signature of informant: [illegible]
 14. Date of statement: [illegible]

BUREAU V. S.

JAN 9 1935

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:

COUNTY Allegany MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town)
 TOWN Cumberland LENGTH OF STAY (In this place) 2 hrs.

HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegany
 CITY (If outside corporate limits write RURAL and give nearest town)
 OR
 TOWN Luke

STREET ADDRESS (If rural, give location)
402 Pratt St.

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

WilliamR.Neff

4. DATE OF DEATH

(Month)

(Day)

(Year)

Jan.319 56

5. SEX:

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

married

8. DATE OF BIRTH:

Sept. 1, 1893

9. AGE last birthday:

62

yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life)

Working Foreman, W. Va. Pulp & P. Co.

10b. KIND OF BUSINESS OR INDUSTRY:

Westernport, Md.

11. BIRTHPLACE (State or foreign country):

U.S.A.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

John W. Neff

14. MOTHER'S MAIDEN NAME:

Fannie Grimes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Memorial Hospital records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a) Intracranial hemorrhage due to a 22 caliberrevolver wound in right temporal region

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) point of entrance.(c) Self inflicted.

INTERVAL BETWEEN ONSET AND DEATH

5.3/4 hrs

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

despondent

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY Jan. 3-1956-A.M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR?

Self inflicted 22 caliber wound in right temporal area

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

SIGNATURE

H.V. Deming M.D.

M. D.

CHIEF MEDICAL EXAMINER
 DEPUTY MEDICAL EXAMINER
 ASSISTANT MEDICAL EXAM.

DATE SIGNED
1.3-1956

23. BURIAL, CREMATION, REMOVAL (Specify):

Burial

DATE THEREOF

Jan. 6-1956

NAME OF CEMETERY OR CREMATORY

Philos Cemetery

LOCATION (City, town, or county)

Westernport Allegany Md.

DATE REC'D BY LOCAL REG.

Jan. 4, 1956

REGISTRAR'S SIGNATURE

Walter R. Frantz, M.D.

24. FUNERAL DIRECTOR

E.S. Boal

ADDRESS

Westernport, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 6 1956

RECEIVED

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

Within corporate limits

46

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00070

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|-------------------------|--|-------------------------|---|------------------------|---|-------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>ALLEGANY</u> | | STATE <u>MARYLAND</u> | | COUNTY <u>ALLEGANY</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>CUMBERLAND</u> | | <u>4 DAYS</u> | | TOWN <u>CUMBERLAND</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MEMORIAL HOSPITAL</u> | | | | STREET ADDRESS (If rural give location) <u>20 ELDER STREET</u> | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| <u>SARSH E. NOEL</u> | | | | <u>JAN 7 19 56</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <u>FEMALE</u> | <u>WHITE</u> | <u>WIDOWED</u> | <u>FEBRUARY - 1881</u> | <u>74</u> yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>Housewife</u> | | <u>Own Home</u> | | <u>MARYLAND</u> | | <u>U.S. A.</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>HENRY NOEL</u> | | | | <u>FREDERICK LEASE</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| <u>no</u> | | <u>none</u> | | <u>MEMORIAL AVENUE</u>
<u>MEMORIAL AND WARWICK AVES.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| <u>422.2</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (A) <u>Chronic Myocarditis</u> | | | | | | <u>1 yr</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Secondary Anemia</u> | | | | | | <u>6 mo</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Marriage of Age</u> | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | |
| | | | | | | | |
| 21e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>1/3/56</u>, 19<u>56</u>, to <u>1/7/56</u>, 19<u>56</u>, that I last saw the deceased alive on <u>1/7/56</u>, 19<u>56</u>, and that death occurred at <u>8:03P</u> M, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) | |
| <u>[Signature]</u> | | <u>1-10-56</u> | | <u>Lease Family Cemetery</u> | | <u>Cumberland, Md.</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 24. REC'D BY REGISTRAR | | 25. FUNERAL DIRECTOR'S SIGNATURE | | DATE SIGNED | |
| <u>Burial</u> | | <u>Walter R. Treutz, M.D.</u> | | <u>James F. Scarpelli</u> | | <u>1/9/56</u> | |
| DATE | | REGISTRAR'S SIGNATURE | | ADDRESS | | (State) | |
| <u>1-10-56</u> | | <u>Walter R. Treutz, M.D.</u> | | <u>James F. Scarpelli, Cumberland, Md.</u> | | | |

RECEIVED

47

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY ALLEGANY | | MARYLAND | | STATE MARYLAND | | COUNTY ALLEGANY | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN CUMBERLAND | | 14 DAYS | | TOWN FLINTSTONE | | R.D. #1 | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) Gertrude (Middle) Pauline (Last) NORTH CRAFT | | | | JANUARY 23 | | 19 56 | |
| 5. SEX | | 6. COLOR OR RACE | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | | 8. DATE OF BIRTH | |
| FEMALE | | WHITE | | MARRIED | | OCT. 22, 1906 | |
| | | | | | | 9. AGE last birthday 49 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| | | | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| GEORGE BROCKEY | | | | SUE HUMBERTSON (Missouri) | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT & ADDRESS MEMORIAL HOSPITAL | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | July 54 | |
| 170X IMMEDIATE CAUSE (A) Carcinomatosis of the thorax | | | | | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) Asphyxia | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Carcinoma of the breast | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| July 5, 1956 | | Rt. breast removed. Mastectomy strippl. | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from 1-9-56, to 1-23-56, that I last saw the deceased alive on 1-23-56, and that death occurred at 5:15 A.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE M.A. Williams M.D. | | | | ADDRESS (Street, city, town, state) Cumberland Md. | | DATE SIGNED 1-23-56 | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| Burial | | Jan. 26, 1956 | | Mt. Zion Christ. Cem. | | Near Chaneyville, Penn | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| Jan. 25, 1956 | | Walter R. Trantz, M.D. | | John J. Hafer, Cumberland, Maryland | | | |

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

00071

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

CERTIFICATE OF DEATH

| | | | |
|--|--|------------------------------------|--|
| PLACE OF DEATH
ALLEGANY | | MANNER OF DEATH
SUICIDE | |
| DATE OF DEATH
JANUARY 28, 1956 | | PLACE OF DEATH
GENERAL HOSPITAL | |
| AGE
30 | | SEX
FEMALE | |
| RACE
WHITE | | EDUCATION
HIGH SCHOOL | |
| OCCUPATION
HOUSEWIFE | | RELIGION
METHODIST | |
| MARITAL STATUS
MARRIED | | CAUSE OF DEATH
SUICIDE | |
| IMMEDIATE CAUSE OF DEATH
OVERDOSE OF BARBITURATES | | MORBID CAUSE OF DEATH
SUICIDE | |

Examination of the body of the deceased was made by the undersigned on the 28th day of January, 1956, at the General Hospital, Baltimore, Maryland, and the cause of death was found to be suicide by overdose of barbiturates.

BUREAU V. S.

1-28-56

RECEIVED

JAN 28 1956

NOTICE: This certificate is subject to review by the State Department of Health, Baltimore, Maryland, and the results of such review may be subject to public inspection. The undersigned hereby certifies that the information furnished herein is true and correct to the best of his knowledge and belief.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

DR. DURRETT

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

48

CERTIFICATE OF DEATH

00072

Reg. Dist. No. 4

| | | | | | | | |
|---|--------------------------------------|---|--|---|--|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>ALLEGANY</u> | | STATE <u>MARYLAND</u> COUNTY <u>Alleg.</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u> | | TOWN <u>CUMBERLAND</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u> | | LENGTH OF STAY (in this place) <u>1 DAY</u> | | STREET ADDRESS (If rural give location) <u>R 14 VIRGINIA AVE.</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MEMORIAL HOSPITAL</u> | | | | | | | |
| 3. NAME OF DECEASED (First) <u>LAURA</u> (Middle) <u>V</u> (Last) <u>PARKER</u> | | | | 4. DATE OF DEATH (Month) <u>JAN</u> (Day) <u>17</u> (Year) <u>19 56</u> | | | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u> | 8. DATE OF BIRTH <u>MAY 8, 1874</u> | 9. AGE last birthday <u>81</u> yrs. | IF UNDER 1 YEAR (Months) <u>17</u> (Days) <u>19</u> | | IF UNDER 24 HRS. (Hours) <u>56</u> (Min.) |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>W VA.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>HIDER STONEBRAKER</u> | | | | 14. MOTHER'S MAIDEN NAME <u>SUSAN SHROUT</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service) <u>none</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT & ADDRESS <u>Mrs. Eva Blake, Cumberland, Md.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 4222 IMMEDIATE CAUSE (A) <u>Cerebral Haemorrhage</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Myocarditis</u> | | | | <u>2 yrs</u> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Jan 2, 1956</u> , to <u>Jan 17, 1956</u> , that I last saw the deceased alive on <u>Jan 17, 1956</u> , and that death occurred at <u>3:42 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Clayton L. Durrett</u> M.D. | | | | ADDRESS (Street, city, town, state) <u>Cumberland</u> DATE SIGNED <u>1/18/56</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>Jan. 20, 1956</u> | | NAME OF CEMETERY OR CREMATORY <u>Rose Hill Crypt</u> | | LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u> | |
| 24. REC'D BY REGISTRAR <u>Jan 20, 1956</u> | | REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarcelli</u> ADDRESS <u>Cumberland, Md.</u> | | | |

BUREAU V. S.

JAN 23 1956

RECEIVED

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE, MD

DATE OF DEATH

1956

1. NAME OF DECEASED

2. SEX

3. RACE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. DATE OF DEATH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. SIGNATURE

10. SIGNATURE

11. SIGNATURE

12. SIGNATURE

13. SIGNATURE

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17. SIGNATURE

18. SIGNATURE

19. SIGNATURE

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26. SIGNATURE

RECEIVED

RECEIVED
JAN 23 1956
BUREAU V. S.

CERTIFICATE OF DEATH

00073

Reg. Dist. No. 4

DR. W.F. WILLIAMS

49

| | | | | | | | |
|--|------------------|--|------------------|---|-----------------|---|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY ALLEGANY | | MARYLAND | | STATE MARYLAND | | COUNTY ALLEGANY | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN CUMBERLAND | | 3 DAYS | | TOWN CUMBERLAND | | 02 | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| MEMORIAL HOSPITAL | | | | 508 PARK STREET | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) VERDEEN (Middle) R. (Last) PARSONS | | | | (Month) JANUARY (Day) 13 (Year) 19 56 | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| MALE | WHITE | MARRIED | MAY 20, 1930 | 25 yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Restaurant Mgr. | | Restaurant Business | | MARYLAND Cumberland, | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| VERDEEN PARSONS | | | | LOUISE KELLER | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| No, | | 728-01-3961 | | MEMORIAL HOSPITAL - CUMBERLAND, MD. | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (A) 592X Chronic Glomerular Nephritis (uremia) | | | | | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) Hypertension | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | M. | | | | | |
| 22. I hereby certify that I attended the deceased from 6:30, 1956, to 1-13-56, that I last saw the deceased alive on 1-12-56, and that death occurred at 2:50 A.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE W.F. Williams | | | | ADDRESS (Street, city, town, state) Cumberland Md | | DATE SIGNED 1-13-56 | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| Burial | | 1/15/56 | | Philos Cemetery | | Westernport, Maryland | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| Jan. 15, 1956 | | Walter L. Frantz, M.D. | | H. Wayne George | | Cumberland, Maryland | |

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

SEX

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

100 BACK STREET

HOSPITAL

PERSONS

WHITE

WHITE

DATE OF DEATH

100 BACK STREET

LOUIS KILLER

VERNON TAYLOR

HOSPITAL - QUINERLAND, MD

Chronic Bronchitis (chronic)
Hyperkalemia

BUREAU V. 8

JAN 17 1956

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

83

CERTIFICATE OF DEATH

Reg. Dist. No. 00974

| | | | | | | | |
|--|------------------|--|-------------------------|---|-----------------|---|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | STATE <u>MARYLAND</u> | | STATE <u>Maryland</u> COUNTY <u>Allegany</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>22 Frostburg,</u> | | <u>7 days</u> | | TOWN <u>Frostburg,</u> | | <u>22</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>61 Miner's Hospital</u> | | | | STREET ADDRESS (If rural give location) <u>11 Welsh Street</u> | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| <u>Francis A. Pfaff</u> | | | | <u>Jan. 10th, 1956</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <u>Male</u> | <u>White</u> | <u>Single</u> | <u>Sept. 29th, 1903</u> | <u>52 yrs.</u> | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>Dye House</u> | | <u>Celanese Corp.</u> | | <u>Maryland</u> | | <u>USA</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>Paul Pfaff</u> | | | | <u>Bridget Jack</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| <u>No</u> | | <u>214-07-0071</u> | | <u>Miss Catherine Jack, F'bg, Md.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 260X IMMEDIATE CAUSE (A) <u>Cerebral Edema</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO ANTECEDENT CAUSE(S) (B) <u>Uremia</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Diabetic Nephropathy</u> | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>12</u> , 19 <u>55</u> , to <u>1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/9</u> , 19 <u>56</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>John C. [Signature]</u> M.D. | | | | ADDRESS (Street, city, town, state) | | DATE SIGNED <u>1/10/56</u> | |
| 23. BURIAL, CREMATION REMOVAL (Specify) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>1 - 12-56</u> | | <u>St. Michael's Cemetery</u> | | <u>Frostburg, Md.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| DATE <u>1-12-56</u> | | <u>Mr. Nancy A. Roe</u> | | <u>Joseph R. Durst, Frostburg, Md.</u> | | | |

CERTIFICATE OF DEATH

1. FULL NAME OF DECEASED: **JOHN W. BROWN**

2. SEX: **Male** 3. AGE: **70 years**

4. DATE OF BIRTH: **1888**

5. PLACE OF BIRTH: **St. Louis, Mo.**

6. OCCUPATION: **Retired**

7. CAUSE OF DEATH: **Heart Disease**

8. DATE OF DEATH: **Jan 18 1956**

9. PLACE OF DEATH: **Home**

10. SIGNATURE OF DECEASED: **John W. Brown**

11. SIGNATURE OF WITNESSES: **John W. Brown**

12. SIGNATURE OF PHYSICIAN: **John W. Brown**

13. SIGNATURE OF CORONER: **John W. Brown**

BUREAU V. S.

JAN 18 1956

RECEIVED

14. SIGNATURE OF REGISTRAR: **John W. Brown**

15. SIGNATURE OF CLERK: **John W. Brown**

INSTRUCTIONS

1. This certificate is to be filled out by the physician or coroner who has examined the body of the deceased and has determined the cause of death. It is to be filled out in duplicate, one copy to be retained by the physician or coroner, and the other copy to be forwarded to the Health Department of the State of Maryland, Baltimore, Maryland.

ADDRESS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 9 1951
BUREAU V. S.

50
CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|---|----------------------------------|--|--------------------------------------|---|--|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY Allegany | | MARYLAND | | STATE Maryland | | COUNTY Allegany | |
| CITY (If outside corporate limits, write RURAL OR end give nearest town)
22 TOWN Cumberland | | LENGTH OF STAY (in this place)
9/28/47 | | CITY (If outside corporate limits, write RURAL and give nearest town)
43 TOWN Westernport | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS
91 Allegany County Infirmary | | | | STREET ADDRESS (If rural give location)
Main Street | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) Evelyn | | (Middle) M. | | (Last) Price | | (Month) (Day) (Year)
January 4, 19 56 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
Separated | 8. DATE OF BIRTH
3/27/1903 | 9. AGE last birthday
52 yrs. | IF UNDER 1 YEAR
Months Days
IF UNDER 24 HRS.
Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
John R. Keller | | | | 14. MOTHER'S MAIDEN NAME
Carrie Klencke | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS
Allegany County Infirmary Records | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| IMMEDIATE CAUSE (A) 422.2 Chronic Myocarditis | | | | INTERVAL BETWEEN ONSET AND DEATH
? | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) Parkinson's Disease. | | | | 8 yrs. | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Arthritis Deformans | | | | ? | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.
Carcinoma left breast | | | | ? | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21e. INJURY OCCURRED | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from Jan. 2nd 19 52 , to Jan. 4th 19 56 , that I last saw the deceased alive on Jan. 4th 19 56 , and that death occurred at 2:40 P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE
James E. McLean | | M.D. | | ADDRESS (Street, city, town, state)
49 Greene St. | | DATE SIGNED
1-5-56 | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | DATE THEREOF
Jan. 7, 1956 | | NAME OF CEMETERY OR CREMATORY
Philos Cemetery | | LOCATION (City, town, or county) (State)
Westernport, Maryland | |
| 24. REC'D BY REGISTRAR
Jan 6, 1956 | | REGISTRAR'S SIGNATURE
Walter R. Grantz, M.D. | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
James F. Scarpelli, Cumberland, Maryland | | | |

INSTRUCTIONS

1. **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

50

Reg. Dist. No.

1. NAME OF DECEASED

John S. S. S.

2. SEX

Male

3. AGE

John S. S.

4. DATE OF DEATH

John S. S.

5. PLACE OF DEATH

John S. S.

6. CAUSE OF DEATH

John S. S.

7. MANNER OF DEATH

John S. S.

8. SIGNATURE OF PHYSICIAN

John S. S.

9. SIGNATURE OF REGISTRAR

John S. S.

10. SIGNATURE OF WITNESSES

John S. S.

11. SIGNATURE OF CORONER

John S. S.

12. SIGNATURE OF JURY

John S. S.

13. SIGNATURE OF JUDGE

John S. S.

14. SIGNATURE OF CLERK

John S. S.

15. SIGNATURE OF NOTARY

John S. S.

16. SIGNATURE OF SHERIFF

John S. S.

17. SIGNATURE OF DEPUTY SHERIFF

John S. S.

1. NAME OF DECEASED

John S. S.

2. SEX

Male

3. AGE

John S. S.

4. DATE OF DEATH

John S. S.

5. PLACE OF DEATH

John S. S.

6. CAUSE OF DEATH

John S. S.

7. MANNER OF DEATH

John S. S.

8. SIGNATURE OF PHYSICIAN

John S. S.

9. SIGNATURE OF REGISTRAR

John S. S.

10. SIGNATURE OF WITNESSES

John S. S.

11. SIGNATURE OF CORONER

John S. S.

12. SIGNATURE OF JURY

John S. S.

13. SIGNATURE OF JUDGE

John S. S.

14. SIGNATURE OF CLERK

John S. S.

15. SIGNATURE OF NOTARY

John S. S.

16. SIGNATURE OF SHERIFF

John S. S.

17. SIGNATURE OF DEPUTY SHERIFF

John S. S.

RECEIVED

BUREAU V. S.

JAN 9 1911

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00077

84 **CERTIFICATE OF DEATH**

Reg. Dist. No. 9

| | | | | | | | |
|--|-------------------------------------|---|---|---|---|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | STATE <u>Md.</u> | | COUNTY <u>Allegany</u> | | | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Frostburg</u> | | <u>40yrs</u> | | TOWN <u>Frostburg</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>I83 McCulloh St.</u> | | | | STREET ADDRESS (If rural give location) <u>I83 McCulloh St.</u> | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last)
<u>Vincent L. Reckley</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year)
<u>I 15 19 56</u> | | | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
<u>Single</u> | 8. DATE OF BIRTH
<u>II-2-1909</u> | | 9. AGE last birthday
<u>46 yrs.</u> | 10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)
<u>15 19 56</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Employee</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>City of Frostburg</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Kifer, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | |
| 13. FATHER'S NAME
<u>Vincent S. Reckley</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Margaret Dailey</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
<u>Yes World War II</u> | | 16. SOCIAL SECURITY NO.
<u>2I2-I8-I672</u> | | 17. INFORMANT & ADDRESS <u>Frostburg, Md.</u>
<u>Mrs. Lottie Bevans, I83 McCulloh</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 154X IMMEDIATE CAUSE (A) <u>Carcinoma of Rectum</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 mo</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) _____ | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) _____ | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Oct 17</u> , 19 <u>53</u> , to <u>Jan 15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 15</u> , 19 <u>56</u> , and that death occurred at <u>11:15 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Wm Lane MD</u> M.D. | | | | ADDRESS (Street, city, town, state) <u>Frostburg Md</u> | | DATE SIGNED <u>Jan 16 56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | | DATE THEREOF
<u>I-18-1956</u> | | NAME OF CEMETERY OR CREMATORY
<u>Frostburg Memorial Park Frostburg, Md.</u> | | LOCATION (City, town, or county) (State) | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| <u>1-18-56</u> | | <u>Wm Nancy N. Ritz</u> | | <u>Jacob Hafer</u> | | <u>Frostburg, Md.</u> | |

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE, MD.

100000

Reg. Dist. No.

1. Usual Residence of Deceased

Place of Birth

Year of Birth

Married

Age

Sex

Usual Residence of Deceased

2. Cause of Death

3. Date of Death

4. Place of Death

5. Signature of Physician

6. Signature of Registrar

7. Signature of Coroner

8. Signature of Medical Examiner

9. Signature of Burial Officer

10. Signature of Undertaker

11. Signature of Funeral Home

12. Signature of Cemetery

13. Signature of Burial

14. Signature of Burial

15. Signature of Burial

16. Signature of Burial

17. Signature of Burial

18. Signature of Burial

19. Signature of Burial

20. Signature of Burial

21. Signature of Burial

22. Signature of Burial

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55. Signature of Burial

55. Signature of Burial

56. Signature of Burial

RECEIVED

BUREAU V. S.

JAN 24 1900

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00078

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY Allegany | | STATE Maryland COUNTY Allegany | | CITY (If outside corporate limits, write RURAL and give nearest town) | | CITY (If outside corporate limits, write RURAL and give nearest town) | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | TOWN | | TOWN | |
| TOWN Cumberland | | 8/3/54 | | Frostburg | | 22 | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| Allegany County Infirmary | | | | 84 E. Mechanic St. | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) Louis | | (Middle) Riley | | (Month) January 7, | | (Day) 1956 | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single | | 8. DATE OF BIRTH 4/6/1883 | |
| 9. AGE last birthday 72 yrs. | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | IF UNDER 24 HRS. | |
| | | Months | | Days | | Hours | |
| | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender | | | | 10b. KIND OF BUSINESS OR INDUSTRY Tavern Owner | | 11. BIRTHPLACE (State or foreign country) Unknown | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Unknown | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No | | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT & ADDRESS Allegany County Infirmary Records | |
| 18. MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE (A) Chronic Myocarditis | | | | | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) Cerebral arteriosclerosis | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Chronic Nephritis | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Senile psychosis. | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. MAJOR FINDINGS OF OPERATION | | | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) | | (County) (State) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21e. INJURY OCCURRED | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from Aug. 3, 1954 , to Jan. 7, 1956 , that I last saw the deceased alive on Jan. 6, 1956 , and that death occurred at 9:45 A.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE James E. McLean | | | | ADDRESS (Street, city, town, state) 49 Greene St. | | | |
| DATE SIGNED 1-7-56 | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | DATE THEREOF 1 - 10 - 56 | | NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery | | LOCATION (City, town, or county) Frostburg, Md. | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE Walter R. 7 nantz md. | | 25. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst, | | ADDRESS Frostburg, Md. | |
| DATE 1-10-56 | | | | | | | |

CERTIFICATE OF DEATH

FILE NO. 1001

NAME OF DECEASED (PRINT OR TYPE)

NAME OF DECEASED (PRINT OR TYPE)

DATE OF DEATH

PLACE OF DEATH

CITY

COUNTY

STATE

SEX

AGE

DATE OF BIRTH

TIME

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF DEATH

TIME

DATE OF DEATH

PLACE OF DEATH

CITY

COUNTY

NAME OF DECEASED (PRINT OR TYPE)

DATE OF DEATH

PLACE OF DEATH

BUREAU V. S.

JAN 12 1956

RECEIVED

DATE OF DEATH

PLACE OF DEATH

CITY

COUNTY

52

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|---|---------------------------|---|----------------------------------|--|--------------------------------|--|--------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY ALLEGANY | | MARYLAND | | STATE PENNA. | | COUNTY BEDFORD | |
| CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN CUMBERLAND, | | LENGTH OF STAY (In this place)
60 DAYS | | CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN BRN BUFFALO MILLS, PA. | | 75x-8 | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS
MEMORIAL HOSPITAL
MEMORIAL & WARWICK AVES., | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) BRUCE (Middle) L. (Last) ROBERTSON | | | | (Month) JAN. (Day) 7 (Year) 1956 | | | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED | 8. DATE OF BIRTH
NOV. 9, 1909 | 9. AGE last birthday
46 yrs. | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
FARMER | | 10b. KIND OF BUSINESS OR INDUSTRY
OWN FARM | | 11. BIRTHPLACE (State or foreign country)
BUFFALO MILLS, PA. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
ANDREW ROBERTSON | | | | 14. MOTHER'S MAIDEN NAME
CARRIE MAY | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)
No | | 16. SOCIAL SECURITY NO.
161-12-6658 | | 17. INFORMANT & ADDRESS
MEMORIAL HOSPITAL | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 157X IMMEDIATE CAUSE (A) Carcinoma of pancreas | | | | INTERVAL BETWEEN ONSET AND DEATH
Approx 6 months | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) General abdominal metastases | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION
Nov 9, 1955 | | 19b. MAJOR FINDINGS OF OPERATION
Carcinoma pancreas with metastases to liver | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21e. INJURY OCCURRED | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from Nov 2, 1955, to Jan 7, 1956, that I last saw the deceased alive on Jan 7, 1956, and that death occurred at 4:45 A.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE
Wayne M. Fawcett | | | | DATE SIGNED
Jan 7 1956 | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | DATE THEREOF
Jan. 9, 1956 | | NAME OF CEMETERY OR CREMATORY
Trinity Reformed Cem. | | LOCATION (City, town, or county) (State)
Mann's Choice, Pennsylvania. | |
| 24. REC'D BY REGISTRAR
Jan 9, 1956 | | REGISTRAR'S SIGNATURE
Walter R. Hantz, M.D. | | 25. FUNERAL DIRECTOR'S SIGNATURE
Harvey H. Zeigler, Hyndman, Pennsylvania. | | ADDRESS | |

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After the certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

I. PLACE OF DEATH:

COUNTY Allegany MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) LENGTH OF STAY (In this place)
 TOWN Cumberland 1-1/4 yrs.
 HOSPITAL OR 761 Fayette St.
 INSTITUTION OR
 STREET ADDRESS Crumps Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegany
 CITY (If outside corporate limits write RURAL and give nearest town) OR
 TOWN Little Orleans
 STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED:

(First) (Middle) (Last)
 (Type or Print) John Henry Shipley

4. DATE OF DEATH (Month) (Day) (Year)
Jan. 20 19 56

5. SEX:

male

6. COLOR OR RACE:
White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):
Single

8. DATE OF BIRTH:

March 13-1860

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.
95 yrs. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, Retired):

Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

Gen. Farming

11. BIRTHPLACE (State or foreign country):

Rural) Town Hill, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

Samuel Shipley

14. MOTHER'S MAIDEN NAME:

Nancy Potts

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY No.:

None

17. INFORMANT & ADDRESS:

Mrs. W. R. Crump, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

1150.0
 Immediate cause

(a) Generalized arteriosclerosis

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH
?

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

H. V. Deming M.D. H. V. Deming M.D.

CHIEF MEDICAL EXAMINER
 DEPUTY MEDICAL EXAMINER
 ASSISTANT MEDICAL EXAM.

DATE SIGNED Jan. 20-1956

23. BURIAL, CREMATION, REMOVAL (Specify):

Burial

DATE THEREOF

Jan. 23, 1956

NAME OF CEMETERY OR CREMATORY

Fairview Christ. Cem

LOCATION (City, town, or county)

Artemas, Pennsylvania

(State)

DATE REC'D BY LOCAL REG.

Jan. 23, 1956

REGISTRAR'S SIGNATURE

Walter L. Frank, M.D.

24. FUNERAL DIRECTOR

John J. Hafer

ADDRESS

Cumberland, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 24 1956

RECEIVED

Within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00081

54

CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After the certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of the death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

| | | | | | | | |
|--|-------------------------------|--|--------------------------------------|--|-----------------|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | STATE <u>Maryland</u> | | COUNTY <u>Allegany</u> | | | |
| CITY (If outside corporate limits, write RURAL or give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Cumberland</u> | | <u>23 days</u> | | TOWN <u>Rawlings</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u> | | | | STREET ADDRESS (If rural give location) <u>Rt. 220 at Rawlings</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <u>Joseph</u> (Middle) <u>Skelley</u> (Last) | | | | (Month) <u>Jan.</u> (Day) <u>28</u> (Year) <u>1956</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>Feb. 12 1872</u> | 9. AGE last birthday <u>83</u> yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farm owner</u> | | 11. BIRTHPLACE (State or foreign country) <u>New Baltimore, Penna.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John Skelley</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Rachael Thomas</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT & ADDRESS <u>Mr. Harry Skelly Cumberland, Md.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 420.1 IMMEDIATE CAUSE (A) <u>Uremia</u> | | | | | | <u>21 Days</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Gangrene, right foot</u> | | | | | | <u>23 Days</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Severe myocardial disease, coronary arteriosclerosis</u> | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Peripheral vascular insufficiency</u> | | | | | | <u>???</u> | |
| 19a. DATE OF OPERATION <u>January 20, 1956</u> | | 19b. MAJOR FINDINGS OF OPERATION <u>Gangrene, Rt. foot, Monckeberg's sclerosis</u> | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21e. INJURY OCCURRED | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Jan. 28, 1956</u> to <u>Jan. 28, 1956</u> , that I last saw the deceased alive on <u>Jan. 28, 1956</u> , and that death occurred at <u>5:10 p.m.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Samuel J. Johnson</u> | | M.D. <u>50 Pershing St. Cumberland, Md. 1/30/56</u> | | ADDRESS (Street, city, town, state) | | DATE SIGNED | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | DATE THEREOF <u>1/31/56</u> | | NAME OF CEMETERY OR CREMATORY <u>St. Ambrose Cem.</u> | | LOCATION (City, town, or county) (State) <u>Cresaptown, Maryland</u> | |
| 24. REC'D BY REGISTRAR <u>Jan. 31, 1956</u> | | REGISTRAR'S SIGNATURE <u>Walter R. Frank, M.D.</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u> | | ADDRESS <u>Cumberland, Md.</u> | |

MD010012M

THIS IS A SUMMARY OF THE INFORMATION RECEIVED FROM THE BUREAU OF VITAL STATISTICS OF THE STATE OF MARYLAND, AND IS NOT A SUBSTITUTE FOR THE ORIGINAL RECORDS. IT IS INTENDED TO BE USED FOR INFORMATIONAL PURPOSES ONLY. THE INFORMATION CONTAINED HEREIN IS NOT TO BE USED FOR ANY OTHER PURPOSES WITHOUT THE EXPRESS WRITTEN PERMISSION OF THE BUREAU OF VITAL STATISTICS.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

See How to Fill Out This Certificate

1. NAME OF DECEASED

2. SEX

3. DATE OF BIRTH

4. PLACE OF BIRTH

5. OCCUPATION

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. SIGNATURE OF PHYSICIAN

9. SIGNATURE OF REGISTRAR

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF DECEASED

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BUREAU V. S.

FEB 2 1955

RECEIVED

St. Andrews, Md.

1/21/55

1/21/55

Charles L. Moore, Baltimore, Md.

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|---|-------------------------------|--|-----------------------------------|---|-----------------|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY Allegany | | STATE Maryland | | COUNTY Allegany | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN Cumberland | | 10/8/55 | | TOWN Cumberland | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary | | | | STREET ADDRESS (If rural give location) 607 Washington Street | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) Mary | | (Middle) Virginia | | (Last) Sloan | | (Month) (Day) (Year) January 5, 1956 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow | 8. DATE OF BIRTH 10/1/1862 | 9. AGE last birthday 93 yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own home | | 11. BIRTHPLACE (State or foreign country) Long Green, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Dixon Connolly | | | | 14. MOTHER'S MAIDEN NAME Elizabeth Gorsuch | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT & ADDRESS Allegany County Infirmary Records | | | |
| 18. MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE (A) Pulmonary Congestion | | | | 16 hrs | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) Chronic Myocardial Degeneration | | | | ? | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Cerebral Arteriosclerosis | | | | ? | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic Hepatitis | | | | ? | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from Oct. 8th, 1955 to Jan 5th, 1956 , that I last saw the deceased alive on Jan 4th, 1956 , and that death occurred at 2:40 P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE James E. McLean | | M.D. | | ADDRESS (Street, city, town, state) 44 Green St. Hagerstown Md. | | DATE SIGNED 1-5-56 | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | DATE THEREOF 1/7/1956 | | NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park | | LOCATION (City, town, or county) (State) Frostburg Maryland | |
| 24. REC'D BY REGISTRAR Jan 7, 1956 | | REGISTRAR'S SIGNATURE Walter R. Gantz, M.D. | | 25. FUNERAL DIRECTOR'S SIGNATURE (Address) Louis Stein, Inc. Cumberland, Md. | | | |

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

00083

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH

Reg. No. 11

A. 1932 MICHIGAN-CHIEF OF CHICAGO

Allegany

Chapman

Boy Washington 20-25

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10/1/1932

1000 Green, Maryland E. S. A.

Coroner

Allegany

Allegany County, Maryland

ALLEGANY COUNTY, MARYLAND

BUREAU V. S.

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RECEIVED

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CERTIFICATE OF DEATH

Reg. Dist. No. 4

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|--|------------------|--|------------------|---|-----------------|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY ALLEGANY | | MARYLAND | | STATE Maryland | | COUNTY Allegany | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN Cumberland | | 29 Days | | TOWN Cresaptown | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS | | | |
| Crump Nursing Home
761 Fayette Street | | | | (If rural give location) | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| BERTHA MAY SMITH | | | | January 31 1956 | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| Female | White | Widowed | July 4, 1889 | 66 yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Housewife | | Own Home | | Pennsylvania | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| EDWARD HAYES | | | | SUSAN STEFFIE | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| None | | None | | Susan Smith, Cresaptown, Md. | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| IMMEDIATE CAUSE (A) | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| Coronary Occlusion | | | | 2 da. | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | 204R. | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | | 104R. | | | |
| DUE TO | | | | | | | |
| Coronary Sclerosis | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| Generalized Rheumatoid Arthritis | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? | | | |
| None | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| | | None | | None | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from Jan 10, 1955, to Jan 31, 1956, that I last saw the deceased alive on Jan 31, 1956, and that death occurred at 7:00 P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | | | ADDRESS (Street, city, town, state) | | | |
| J. Haefner MD 140 Bedford St | | | | DATE SIGNED 1-31-1956 | | | |
| M. D. Cumberland, Md. | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| Burial | | Feb. 2, 1956 | | Zion Memorial Park | | Cumberland, Maryland | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| Feb. 1, 1956 | | Walter R. Frantz, M.D. | | John J. Hafer, | | Cumberland, Maryland | |

INSTRUCTIONS

1 Within corporate limits

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

00083

DEPARTMENT OF HEALTH - BALTIMORE

CERTIFICATE OF DEATH

50

Rev. Dr. H. H. H.

1. NAME OF DECEASED

2. SEX

3. AGE

4. PLACE OF BIRTH

5. DATE OF BIRTH

6. TIME OF DEATH

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF DECEASED

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BUREAU V. S.

FEB 6 1952

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INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00084

100

CERTIFICATE OF DEATH

Reg. Dist. No. 9

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|---|-------------------------|---|-------------------------|--|------------------------|---|-------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Allegany</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | OR TOWN | |
| X TOWN <u>Eckhart</u> | | <u>19 yrs.</u> | | TOWN <u>Eckhart</u> | | X | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.D. #2, Frostburg, Md.</u> | | | | STREET ADDRESS (If rural give location) <u>R.D. #2, Frostburg, Md.</u> | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| <u>Melvin Lawrence Smouse</u> | | | | <u>1 18 1956</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <u>Male</u> | <u>White</u> | <u>Married</u> | <u>1 - 28 - 1913</u> | <u>42 yrs.</u> | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>Salesman</u> | | <u>Food Company</u> | | <u>Frostburg</u> | | <u>U.S.A.</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>John L. Smouse</u> | | | | <u>Emma Jenkins</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| <u>No</u> | | <u>None</u> | | <u>Frostburg, Md.</u> | | | |
| | | <u>216-09-3821</u> | | <u>Mrs. Melvin Smouse, R.D. #2</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| <u>420.1</u> IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) | | | | | | | |
| STATING UNDERLYING CAUSE LAST. | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.) | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>Jan 18 1956</u> to <u>Jan 18 1956</u>, that I last saw the deceased alive on <u>Jan 18 1956</u>, and that death occurred at <u>8:05 P</u> M, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | ADDRESS (Street, city, town, state) | | DATE SIGNED | | | |
| <u>Wome Lane MD</u> | | <u>Frostburg Md</u> | | <u>Jan 20 1956</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>1 - 21 - 56</u> | | <u>Eckhart Cemetery</u> | | <u>Eckhart Md.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| <u>1-21-56</u> | | <u>Mrs. Nancy H. Rose</u> | | <u>Burial H. Montiscent</u> | | <u>23 E. Main Frostburg, Md.</u> | |

ENCLOSURE

RECEIVED JAN 24 1956

RECEIVED JAN 24 1956

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

BUREAU V. S.

JAN 24 1956

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of the death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

I This certificate must be executed within 24 hours after death.

DR LEY

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00085

57

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|---|------------------|--|-----------------------------------|---|---|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY ALLEGANY | | MARYLAND | | STATE MARYLAND | | COUNTY GARRETT | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN CUMBERLAND | | 6 DAYS | | TOWN GRANTSVILLE, rural (Jennings) | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| MEMORIAL HOSPITAL | | | | 11X-2 ✓ | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | 5. AGE last birthday | |
| (First) (Middle) (Last) | | | | (Month) (Day) (Year) | | (Years) (Months) (Days) (Hours) (Min.) | |
| ELMER SNYDER | | | | JAN 17 1956 | | 55 yrs. | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | | IF UNDER 1 YEAR | |
| MALE | WHITE | WIDOWED | JAN 29, 1900 | 55 | | Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | |
| Lumberman and Sawyer | | | Odd jobs | | MARYLAND | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| AUGUST SNYDER | | | | MARY E BITTINGER | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| Yes W. W. II | | 212-18-1002 | | Memorial Hospital | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 591.0 IMMEDIATE CAUSE (A) | | | | Interval BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | Cerebral | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE | | | | | | | |
| STATING UNDERLYING CAUSE LAST, DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from 1/11, 1956, to 1/17, 1956, that I last saw the deceased alive on 1/17, 1956, and that death occurred at 4:12 PM, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | | | ADDRESS (Street, city, town, state) | | DATE SIGNED | |
| [Signature] | | | | M.D. Cumberland Md | | 1/19/56 | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| BURIAL | | Jan. 21, 1956 | | Snyder Cemetery | | near Jennings, Maryland. | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS | | | |
| Jan. 20, 1956 | | Walter F. Frantz, M.D. | | Donald L. Berman - Grantsville Md. | | | |

CERTIFICATE OF DEATH

Reg. No. 100

1. Name of deceased (Print or type)

2. Date of death (Month, day, year)

3. Place of death

4. Cause of death

5. Name of physician (Print or type)

6. Name of funeral director (Print or type)

7. Name of hospital (Print or type)

8. Name of informant (Print or type)

9. Name of registrar (Print or type)

10. Name of witness (Print or type)

11. Name of witness (Print or type)

12. Name of witness (Print or type)

13. Name of witness (Print or type)

14. Name of witness (Print or type)

15. Name of witness (Print or type)

BUREAU V. 2

JAN 23 1956

RECEIVED

RECEIVED

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:

COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland LENGTH OF STAY (in this place) 40 Yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Dead on arrival at the Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegany
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS 108 Polk St. (If rural, give location)

3. NAME OF DECEASED: (First) Nicholas (Middle) a (Last) Spano
(Type or Print)

4. DATE OF DEATH (Month) (Day) (Year)
Jan. 30 19 56

5. SEX: male 6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married 8. DATE OF BIRTH: May 15-1888

9. AGE last birthday: 67 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Photographer

10b. KIND OF BUSINESS OR INDUSTRY: Electric Studio -

11. BIRTHPLACE (State or foreign country): Macedonia, Greece

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Athanasios Spano Self employed

14. MOTHER'S MAIDEN NAME: Mary Papahagi

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 214-34-1302

17. INFORMANT & ADDRESS: (son) Arthur N. Spano, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1
Immediate cause (a) Coronary occlusion DUE TO
Antecedent cause(s) (b) Coronary sclerosis
Diseases or conditions, if any, giving rise to the above cause DUE TO
stating underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH
sudden
2 years.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H.V. Deming M.D. CHIEF MEDICAL EXAMINER ☐ DATE SIGNED Jan. 30/56
DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐

23. BURIAL, CREMATION, REMOVAL (Specify): Burial DATE THEREOF Feb. 1, 1956 NAME OF CEMETERY OR CREMATORY Free Will Cemetery, Cumberland, Maryland LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. Jan. 31, 1956 REGISTRAR'S SIGNATURE Walter R. Frantz, M.D. 24. FUNERAL DIRECTOR Charles L. George ADDRESS

RECEIVED

FEB 2 1934

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00087

59

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|---|-------------------------------------|---|---|---|---------------------------------------|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | STATE <u>Maryland</u> | | COUNTY <u>Allegany</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Cumberland</u> | | <u>1yr. 9mo.</u> | | TOWN <u>Rawlings</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sylvan Retreat</u> | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| <u>Simon Johnson Spencer</u> | | | | <u>January 26 1956</u> | | | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
<u>Married</u> | 8. DATE OF BIRTH
<u>August 29, 1873</u> | 9. AGE last birthday
<u>82</u> yrs. | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Car Man</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>B. & O. Ry. Co.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Mineral Co., W. Va.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Jerome H. Spencer</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Susan C. Stark Fleek</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | | 17. INFORMANT & ADDRESS
<u>Stanley Spencer (son) Keyser, W. Va.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| IMMEDIATE CAUSE (A) <u>334X</u> | | | | <u>Pulmonary Hypostasis</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) | | | | <u>Chronic Myocardial Degeneration</u> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) | | | | <u>Cerebral arteriosclerosis</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | <u>Senile psychosis</u> | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>April 8</u> , 19 <u>54</u> , to <u>January 26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan. 25</u> , 19 <u>56</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE
<u>James B. McLean</u> | | | | ADDRESS (Street, city, town, state)
<u>49 Shreve St</u> | | DATE SIGNED
<u>1-26-56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | | DATE THEREOF
<u>1/29/56</u> | | NAME OF CEMETERY OR CREMATORY
<u>Queens Point Cem.</u> | | LOCATION (City, town, or county) (State)
<u>Keyser W. Va.</u> | |
| 24. REC'D BY REGISTRAR
<u>Jan. 28, 1956</u> | | REGISTRAR'S SIGNATURE
<u>Winter R. Frantz, M.D.</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE
<u>B. H. Markwood</u> | | ADDRESS
<u>Keyser, W. Va.</u> | |

CERTIFICATE OF DEATH

Reg. 7-1-10

1. Name of deceased (Print or write full name)

2. Sex (Male or Female)

3. Age

4. Date of birth

5. Race

6. Place of birth

7. Usual residence

8. Date of death

9. Time of death

10. Cause of death

11. Place of death

12. Signature of physician

13. Signature of registrar

14. Signature of informant

15. Signature of witness

16. Signature of funeral director

17. Signature of undertaker

18. Signature of cemetery

19. Signature of burial place

20. Signature of interment

21. Signature of cremation

22. Signature of disposition

23. Signature of record

24. Signature of filing

25. Signature of distribution

26. Signature of return

27. Signature of receipt

28. Signature of acknowledgment

29. Signature of compliance

30. Signature of completion

31. Signature of termination

32. Signature of expiration

33. Signature of annulment

34. Signature of dissolution

35. Signature of revocation

36. Signature of withdrawal

37. Signature of release

38. Signature of discharge

39. Signature of exoneration

40. Signature of acquittal

41. Signature of absolution

42. Signature of pardon

43. Signature of amnesty

44. Signature of commutation

45. Signature of remission

46. Signature of mitigation

47. Signature of alleviation

48. Signature of diminution

49. Signature of reduction

50. Signature of abatement

51. Signature of abatement

52. Signature of abatement

53. Signature of abatement

54. Signature of abatement

55. Signature of abatement

56. Signature of abatement

57. Signature of abatement

58. Signature of abatement

59. Signature of abatement

60. Signature of abatement

61. Signature of abatement

62. Signature of abatement

63. Signature of abatement

64. Signature of abatement

65. Signature of abatement

66. Signature of abatement

67. Signature of abatement

68. Signature of abatement

69. Signature of abatement

70. Signature of abatement

71. Signature of abatement

72. Signature of abatement

73. Signature of abatement

74. Signature of abatement

75. Signature of abatement

76. Signature of abatement

77. Signature of abatement

78. Signature of abatement

79. Signature of abatement

80. Signature of abatement

81. Signature of abatement

82. Signature of abatement

83. Signature of abatement

84. Signature of abatement

85. Signature of abatement

86. Signature of abatement

87. Signature of abatement

88. Signature of abatement

89. Signature of abatement

90. Signature of abatement

91. Signature of abatement

92. Signature of abatement

93. Signature of abatement

94. Signature of abatement

95. Signature of abatement

96. Signature of abatement

97. Signature of abatement

98. Signature of abatement

99. Signature of abatement

100. Signature of abatement

BUREAU V. S.

FEB 1 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS-45C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

101

CERTIFICATE OF DEATH

00088

Reg. Dist. No. 6

| | | | | | | | |
|---|-------------------------------|--|--------------------------------------|--|--|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Allegany</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | OR TOWN | |
| TOWN <u>Westernport rural</u> | | <u>23 yrs</u> | | <u>Westernport rural</u> | | <u>X</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1 mile N of Westernport</u> | | | | STREET ADDRESS (If rural give location) <u>1 mile N of Westernport</u> | | | |
| 3. NAME OF DECEASED
(Type or Print) <u>Leona</u> (First) <u>Atheline</u> (Middle) <u>Stevenson</u> (Last) | | | | 4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>2</u> (Year) <u>19</u> <u>56</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>15 July 1881</u> | 9. AGE last birthday <u>74</u> yrs. | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>domestic</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Mannington, W. Va.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>US</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME <u>Zella Lease</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT & ADDRESS <u>Samuel Stevenson, as in 2. above</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>5hrs</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterion Sclerosis</u> | | | | | | <u>5yrs</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hypertention Essential</u> | | | | | | <u>10 yrs</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21e. INJURY OCCURRED | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Dec</u> , 19 <u>54</u> , to <u>Jan 2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/2</u> , 19 <u>56</u> , and that death occurred at <u>12.50 P.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>[Signature]</u> | | | | ADDRESS (Street, city, town, state) <u>Piedmont W Va</u> | | DATE SIGNED <u>1/5 /56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u> | | DATE THEREOF <u>Jan 5 56</u> | | NAME OF CEMETERY OR CREMATORY <u>Bloomington, Cem</u> | | LOCATION (City, town, or county) (State) <u>Bloomington, Md.</u> | |
| 24. REC'D BY REGISTRAR <u>1-5-56</u> | | REGISTRAR'S SIGNATURE <u>[Signature]</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> | | ADDRESS <u>Westernport, Md.</u> | |

SMOKESTUBS

THE SMOKESTUBS are the most reliable and accurate means of recording the temperature of the atmosphere at any point. They are made of the finest materials and are designed to withstand the most severe conditions of use. They are available in a variety of sizes and shapes to suit the requirements of different applications. The SMOKESTUBS are used in a wide range of industries, including chemical, pharmaceutical, and food processing. They are also used in research laboratories and in the home. The SMOKESTUBS are a valuable tool for anyone who needs to measure the temperature of the atmosphere accurately.

CERTIFICATE OF DEATH

ANNEXED STATE DEPARTMENT OF HEALTH-BALTIMORE 19

00088

1. PLACE OF DEATH

2. COUNTY

3. DISTRICT

4. CITY

5. STREET

6. APARTMENT

7. ROOM

8. BUILDING

9. BLOCK

10. LOT

11. TRACT

12. SECTION

13. TOWNSHIP

14. RANGE

15. MERIDIAN

16. COUNTY

17. STATE

18. ZIP CODE

19. CENSUS TRACT

20. BLOCK

21. LOT

22. TRACT

23. SECTION

24. TOWNSHIP

25. RANGE

26. MERIDIAN

27. COUNTY

28. STATE

29. ZIP CODE

30. CENSUS TRACT

31. BLOCK

32. LOT

33. TRACT

34. SECTION

35. TOWNSHIP

36. RANGE

37. MERIDIAN

38. COUNTY

39. STATE

40. ZIP CODE

41. CENSUS TRACT

42. BLOCK

43. LOT

44. TRACT

45. SECTION

46. TOWNSHIP

47. RANGE

48. MERIDIAN

49. COUNTY

50. STATE

51. ZIP CODE

52. CENSUS TRACT

53. BLOCK

54. LOT

55. TRACT

56. SECTION

57. TOWNSHIP

58. RANGE

59. MERIDIAN

60. COUNTY

61. STATE

62. ZIP CODE

63. CENSUS TRACT

64. BLOCK

65. LOT

66. TRACT

67. SECTION

68. TOWNSHIP

69. RANGE

70. MERIDIAN

71. COUNTY

72. STATE

73. ZIP CODE

74. CENSUS TRACT

75. BLOCK

76. LOT

77. TRACT

78. SECTION

79. TOWNSHIP

80. RANGE

81. MERIDIAN

82. COUNTY

83. STATE

84. ZIP CODE

85. CENSUS TRACT

86. BLOCK

87. LOT

88. TRACT

89. SECTION

90. TOWNSHIP

91. RANGE

92. MERIDIAN

93. COUNTY

94. STATE

95. ZIP CODE

96. CENSUS TRACT

97. BLOCK

98. LOT

99. TRACT

100. SECTION

101. TOWNSHIP

102. RANGE

103. MERIDIAN

104. COUNTY

105. STATE

106. ZIP CODE

107. CENSUS TRACT

108. BLOCK

109. LOT

110. TRACT

111. SECTION

112. TOWNSHIP

113. RANGE

114. MERIDIAN

115. COUNTY

116. STATE

117. ZIP CODE

118. CENSUS TRACT

119. BLOCK

120. LOT

121. TRACT

122. SECTION

123. TOWNSHIP

124. RANGE

125. MERIDIAN

126. COUNTY

127. STATE

128. ZIP CODE

129. CENSUS TRACT

130. BLOCK

131. LOT

132. TRACT

133. SECTION

134. TOWNSHIP

135. RANGE

136. MERIDIAN

137. COUNTY

138. STATE

139. ZIP CODE

140. CENSUS TRACT

141. BLOCK

142. LOT

143. TRACT

144. SECTION

145. TOWNSHIP

146. RANGE

147. MERIDIAN

148. COUNTY

149. STATE

150. ZIP CODE

151. CENSUS TRACT

152. BLOCK

153. LOT

154. TRACT

155. SECTION

156. TOWNSHIP

157. RANGE

158. MERIDIAN

159. COUNTY

160. STATE

161. ZIP CODE

162. CENSUS TRACT

163. BLOCK

164. LOT

165. TRACT

166. SECTION

167. TOWNSHIP

168. RANGE

169. MERIDIAN

170. COUNTY

171. STATE

172. ZIP CODE

173. CENSUS TRACT

174. BLOCK

175. LOT

176. TRACT

177. SECTION

178. TOWNSHIP

179. RANGE

180. MERIDIAN

181. COUNTY

182. STATE

183. ZIP CODE

184. CENSUS TRACT

185. BLOCK

186. LOT

187. TRACT

188. SECTION

189. TOWNSHIP

190. RANGE

191. MERIDIAN

192. COUNTY

193. STATE

194. ZIP CODE

195. CENSUS TRACT

196. BLOCK

197. LOT

198. TRACT

199. SECTION

200. TOWNSHIP

201. RANGE

202. MERIDIAN

203. COUNTY

204. STATE

205. ZIP CODE

206. CENSUS TRACT

207. BLOCK

208. LOT

209. TRACT

210. SECTION

211. TOWNSHIP

212. RANGE

213. MERIDIAN

214. COUNTY

215. STATE

216. ZIP CODE

217. CENSUS TRACT

218. BLOCK

219. LOT

220. TRACT

221. SECTION

222. TOWNSHIP

223. RANGE

224. MERIDIAN

225. COUNTY

226. STATE

227. ZIP CODE

228. CENSUS TRACT

229. BLOCK

230. LOT

231. TRACT

232. SECTION

233. TOWNSHIP

234. RANGE

235. MERIDIAN

236. COUNTY

237. STATE

238. ZIP CODE

239. CENSUS TRACT

240. BLOCK

241. LOT

242. TRACT

243. SECTION

244. TOWNSHIP

245. RANGE

246. MERIDIAN

247. COUNTY

248. STATE

249. ZIP CODE

250. CENSUS TRACT

251. BLOCK

252. LOT

253. TRACT

254. SECTION

255. TOWNSHIP

256. RANGE

257. MERIDIAN

258. COUNTY

259. STATE

260. ZIP CODE

261. CENSUS TRACT

262. BLOCK

263. LOT

264. TRACT

265. SECTION

266. TOWNSHIP

267. RANGE

268. MERIDIAN

269. COUNTY

270. STATE

271. ZIP CODE

272. CENSUS TRACT

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

85

00089

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 9

Reg. Dist.

| | | | | | | | |
|---|-------------------|--|-------------------|--|------------------|------------------------------|------------|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Md.</u> | | COUNTY <u>Allegany</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits write RURAL and give nearest town) | | OR | |
| TOWN <u>Frostburg</u> | | <u>4 days</u> | | TOWN <u>Frostburg</u> | | <u>22</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u> | | | | STREET ADDRESS (If rural, give location) <u>41 Maple St.</u> | | | |
| 3. NAME OF DECEASED: | | (First) (Middle) (Last) | | 4. DATE OF DEATH | | (Month) (Day) (Year) | |
| (Type or Print) <u>May</u> | | <u>Stewart</u> | | <u>Jan. 22</u> | | <u>19 56</u> | |
| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH: | 9. AGE last birthday: | IF UNDER 24 HRS. | | |
| <u>female</u> | <u>white</u> | <u>married</u> | <u>May 1-1886</u> | <u>69</u> yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY: | | 11. BIRTHPLACE (State or foreign country): | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>housewife</u> | | | | <u>Frostburg, Md.</u> | | <u>U.S.A.</u> | |
| 13. FATHER'S NAME: | | | | 14. MOTHER'S MAIDEN NAME: | | | |
| <u>Henry Martig</u> | | | | <u>Hannah Schell</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY No.: | | 17. INFORMANT & ADDRESS: | | | |
| <u>no</u> | | <u>none</u> | | <u>(son) Ralph Stewart, Frostburg, Md.</u> | | | |

| | | | | | |
|--|--|---|--|---|--|
| 18. MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | | | |
| Immediate cause (a) <u>Uremia</u> | | DUE TO | | <u>3 days</u> | |
| Antecedent cause(s) (b) <u>Diabetes mellitus</u> | | DUE TO | | <u>3 yrs.</u> | |
| Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Shock due to a fall</u> | | DUE TO <u>Arteriosclerosis with hypertention</u> | | <u>?</u> | |
| | | | | <u>4 days.</u> | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | |
| <u>Fracture of left femur, surgical neck</u> | | | | <u>4 days.</u> | |
| 19a. DATE OF OPERATION: | | 19b. MAJOR FINDING OF OPERATION: | | 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING* <input checked="" type="checkbox"/> CAUSE OF DEATH. | | 21b. PLACE (Home, farm, factory, street, office bldg., etc., INJURY) <u>home</u> | | 21c. (City or town) (County) (State) <u>Frostburg Allegany Md.</u> | |
| 21d. TIME (Month) (Day) (Year) <u>8:30 AM Jan. 18-1956</u> | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? <u>Walking down stairs fell down 3 steps to kitchen floor.</u> | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | |
| SIGNATURE | | CHIEF MEDICAL EXAMINER | | DATE SIGNED | |
| <u>H. V. Deming M.D.</u> | | <u>H. V. Deming M.D.</u> | | <u>1-23-1956</u> | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | |
| <u>Burial</u> | | <u>1-24-56</u> | | <u>Frostburg Memorial Park, Frostburg, Md.</u> | |
| DATE REC'D BY LOCAL REG. | | REGISTRAR'S SIGNATURE | | M. FUNERAL DIRECTOR ADDRESS | |
| <u>1-24-56</u> | | <u>Mr. Harry N. Roe</u> | | <u>Frank H. Mattingly</u> | |

RECEIVED

FEB 1 1956

BUREAU V. S.

60

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|---|------------------|--|------------------|---|-----------------|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY | | Allegany | | STATE | | S Maryland COUNTY Allegany | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | TOWN | | CITY (If outside corporate limits, write RURAL and give nearest town) | | TOWN | |
| 02 | | Cumberland | | 4/3/54 | | Frostburg 22 | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| 91 | | | | Allegany County Infirmary 5 Standish Street 1 | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) | | (Middle) | | (Last) | | (Month) (Day) (Year) | |
| Regina | | E. | | Sullivan | | January 15, 1956 | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| Female | White | Widow | 5/16/1883 | 72 yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Housewife | | Own Home | | Vale Summit, Maryland | | U. S. A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| John Kirby | | | | Elizabeth Devlin | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| No | | None | | Allegany County Infirmary Records | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| 290.0 | | IMMEDIATE CAUSE (A) | | Chronic Myocardial Degeneration | | ? | |
| ANTECEDENT CAUSE(S) DUE TO | | (B) | | Cerebral Arteriosclerosis | | ? | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | (C) | | Pericarditis | | ? | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | Senile Psychosis | | ? | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) | | (County) (State) | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from Apr. 3, 1956, to Jan. 15, 1956, that I last saw the deceased alive on Jan. 14, 1956, and that death occurred at 11:45 A.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | | | ADDRESS (Street, city, town, state) | | DATE SIGNED | |
| James E. McLean M.D. | | | | 44 Green St. | | 1-16-56 | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| Burial | | 1/17/56 | | St. Michaels Cemetery | | Frostburg, Maryland | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| January 17, 1956 | | Walter R. Huntz M.D. | | Hager Funeral Home, Frostburg, Maryland | | | |

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of the death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

60

Reg. Div. No.

1. FULL NAME (PRINTED) OF DECEASED

Allegany Maryland

2. SEX

Allegany

3. AGE

1/2

4. OCCUPATION

5. PLACE OF BIRTH

6. DATE OF DEATH

7. TIME OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF BURIAL OFFICIAL

15. PLACE OF BURIAL

16. NAME OF BURIAL PLACE

17. NAME OF BURIAL PLACE

18. NAME OF BURIAL PLACE

19. NAME OF BURIAL PLACE

BUREAU V. S.

JAN 18 1956

RECEIVED

20. NAME OF BURIAL PLACE

21. NAME OF BURIAL PLACE

22. NAME OF BURIAL PLACE

NOTARY PUBLIC

NOTARY PUBLIC

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00091

102

CERTIFICATE OF DEATH

Reg. Dist. No. 9

| | | | |
|---|--------------------------------|--|---|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED | |
| COUNTY <u>Allegany</u> | MARYLAND | STATE <u>Md.</u> | COUNTY <u>Allegany</u> |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X</u> <u>Zihlman</u> | LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Zihlman</u> | <u>FROSTBURG</u> <u>X</u> |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.D. #2 Box 324</u> | | STREET ADDRESS (If rural give location) <u>R.D. #2 Box 324</u> | |
| 3. NAME OF DECEASED (Type or Print) <u>JOHN E. SWEEN</u> | | 4. DATE OF DEATH <u>1</u> <u>15</u> <u>19 56</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>4-4-1897</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insulation</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Celanese Corp</u> | 11. BIRTHPLACE (State or foreign country) <u>Zihlman, Md.</u> |
| 13. FATHER'S NAME <u>William Sween</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Steven</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> <u>World War I</u> | | 17. INFORMANT & ADDRESS <u>R.D. #2, Box 324</u>
<u>John Sween, Jr. Frostburg, Md.</u> | |
| 18. MEDICAL CERTIFICATION | | | INTERVAL BETWEEN ONSET AND DEATH |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | |
| 151X IMMEDIATE CAUSE (A) <u>Granuloma</u> | | | <u>2 weeks</u> |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma</u> | | | <u>2 months</u> |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Carcinoma, Stomach, Fundus</u> | | | <u>6 months</u> |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19a. DATE OF OPERATION <u>10/5-5</u> | | 19b. MAJOR FINDINGS OF OPERATION <u>CARCINOMA Fundus Stomach.</u> | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (Second) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>9/15</u> , 19 <u>55</u> , to <u>1/16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/15</u> , 19 <u>56</u> , and that death occurred at <u>2 A.</u> M., from the causes and on the date stated above. | | | |
| SIGNATURE <u>John C. Sween</u> M.D. | | ADDRESS (Street, city, town, state) <u>Frostburg</u> DATE SIGNED <u>1/16/56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>1-17-1956</u> | |
| NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park</u> | | LOCATION (City, town, or county) <u>Frostburg Md.</u> | |
| 24. REC'D BY REGISTRAR <u>Miss Nancy H. Roe</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Bruce H. Mont...</u> ADDRESS <u>23 East Main Frostburg, Md.</u> | |

Will be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00092

61

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|--|---|--|---|--|---|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY ALLEGANY | | STATE MARYLAND | | COUNTY ALLEGANY | | | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)
CUMBERLAND, | | LENGTH OF STAY (in this place)
9 DAYS | | CITY (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | |
| TOWN | | | | STREET ADDRESS (If rural give location)
118 N. SPRUCE ST. | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS
MEMORIAL HOSPITAL | | | | | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) FRANCES (Middle) M. (Last) TEETERS | | | | (Month) JAN. (Day) 2 (Year) 1956 | | | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
SINGLE | 8. DATE OF BIRTH
APR. 17, 1876 | | 9. AGE last birthday
79 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10b. KIND OF BUSINESS OR INDUSTRY
None | | 11. BIRTHPLACE (State or foreign country)
Dayton, Ohio. | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
John TEETERS | | | | 14. MOTHER'S MAIDEN NAME
CROUSTER, JEANNETTE | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT & ADDRESS
Mrs. Bertha Gormer Cumberland Md. | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 153X IMMEDIATE CAUSE (A) Carcinoma Colon with liver metastasis | | | | INTERVAL BETWEEN ONSET AND DEATH
2+ years | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) Cachexia from Carcinoma Colon | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION
July 13, 1955 | | 19b. MAJOR FINDINGS OF OPERATION
Inoperable Carcinoma Sigmoid Colon | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work | | 21e. INJURY OCCURRED | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from Jan 5, 1956, to Jan 2, 1956, that I last saw the deceased alive on Jan 1, 1956, and that death occurred at 3:35 A.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE
Wm. T. Taylor | | | | DATE SIGNED
Jan 3, 1956 | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | DATE THEREOF
1-5-1956 | | NAME OF CEMETERY OR CREMATORY
St. Patricks Cem. | | LOCATION (City, town, or county) (State)
Cumberland, Md. | |
| 24. REC'D BY REGISTRAR
Jan. 4, 1956 | | REGISTRAR'S SIGNATURE
Walter R. Fantz, M.D. | | 25. FUNERAL DIRECTOR'S SIGNATURE
Charles L. George | | | |
| | | | | Cumberland, Md. | | | |

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

|                                                                                                                 |  |                                             |  |                                                                          |  |                                                                                                                                                                      |  |
|-----------------------------------------------------------------------------------------------------------------|--|---------------------------------------------|--|--------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH:                                                                                              |  |                                             |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:                                   |  |                                                                                                                                                                      |  |
| COUNTY <u>Allegany</u>                                                                                          |  | MARYLAND                                    |  | STATE <u>Md.</u>                                                         |  | COUNTY <u>Allegany</u>                                                                                                                                               |  |
| CITY (If outside corporate limits, write RURAL or and give nearest town)                                        |  | LENGTH OF STAY (in this place)              |  | CITY (If outside corporate limits write RURAL and give nearest town)     |  | OR                                                                                                                                                                   |  |
| TOWN <u>Cumberland</u>                                                                                          |  | <u>12 yrs.</u>                              |  | TOWN <u>Cumberland</u>                                                   |  | <u>02</u>                                                                                                                                                            |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>17 Fifth St.</u>                                                   |  |                                             |  | STREET ADDRESS (If rural, give location) <u>17 Fifth St.</u>             |  |                                                                                                                                                                      |  |
| 3. NAME OF DECEASED: (First) (Middle) (Last)                                                                    |  | 4. DATE OF DEATH (Month) (Day) (Year)       |  | 5. SEX:                                                                  |  | 6. COLOR OR RACE:                                                                                                                                                    |  |
| James T. Twigg                                                                                                  |  | Jan. 29 1956                                |  | male                                                                     |  | white                                                                                                                                                                |  |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Divorced</u>                                               |  | 8. DATE OF BIRTH: <u>April 1-1891</u>       |  | 9. AGE last birthday: <u>64</u> yrs.                                     |  | 10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Machine Helper-Bolt &amp; Forge B&amp;O.R.R. (rural) Cumberland, Md.</u> |  |
| 11. BIRTHPLACE (State or foreign country): <u>U.S.A.</u>                                                        |  | 12. CITIZEN OF WHAT COUNTRY?                |  | 13. FATHER'S NAME: <u>William R. Twigg</u>                               |  | 14. MOTHER'S MAIDEN NAME: <u>Elizabeth Twigg</u>                                                                                                                     |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u> |  | 16. SOCIAL SECURITY No.: <u>298-01-5467</u> |  | 17. INFORMANT & ADDRESS: <u>(brother) Clayton Twigg, Cumberland, Md.</u> |  |                                                                                                                                                                      |  |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                        |  |                                                                                  |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|--|
| 18. MEDICAL CERTIFICATION                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                        |  | INTERVAL BETWEEN ONSET AND DEATH                                                 |  |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                        |  |                                                                                  |  |
| Immediate cause (a) <u>Chronic myocarditis</u> (sudden death)                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                        |  | ?                                                                                |  |
| DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                        |  |                                                                                  |  |
| Antecedent cause(s) (b) <u>Coronary sclerosis</u>                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                        |  | ?                                                                                |  |
| Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Strangulated hernia</u>                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                        |  |                                                                                  |  |
| DUE TO <u>Grangrene of bowel (slight)</u>                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                        |  |                                                                                  |  |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  |                                                                                  |  |
| 19a. DATE OF OPERATION:                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 19b. MAJOR FINDING OF OPERATION:                                                                       |  | 20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                             |  | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY                                 |  | 21c. (City or town) (County) (State)                                             |  |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR?                                                       |  |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |  |                                                                                                        |  |                                                                                  |  |
| SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | CHIEF MEDICAL EXAMINER                                                                                 |  | DATE SIGNED                                                                      |  |
| <u>H. V. Deming M.D.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | <u>H. V. Deming M.D.</u>                                                                               |  | <u>1-29-1956</u>                                                                 |  |
| 23. BURIAL, CREMATION, REMOVAL (Specify):                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | DATE THEREOF                                                                                           |  | NAME OF CEMETERY OR CREMATORY                                                    |  |
| <u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | <u>Jan. 31, 1956</u>                                                                                   |  | <u>Westcrest Burial Park, Cumberland, Maryland</u>                               |  |
| DATE REC'D BY LOCAL REG.                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | REGISTRAR'S SIGNATURE                                                                                  |  | 24. FUNERAL DIRECTOR ADDRESS                                                     |  |
| <u>Jan. 31, 1956</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | <u>Walter R. Frank, M.D.</u>                                                                           |  | <u>A. Lee Silcox, " "</u>                                                        |  |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 2 1956

RECEIVED



## INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

Within corporate limits **MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

00094

63

## CERTIFICATE OF DEATH

Item 9, FilmG192 2-6-56 et

Reg. Dist. No. 4

|                                                                                                                                                                                                                                                                                 |                                     |                                                                                                               |                                                 |                                                                             |                                                                            |                                                                       |                                                   |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|---------------------------------------------------------------------------------------------------------------|-------------------------------------------------|-----------------------------------------------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------------------------------|---------------------------------------------------|
| <b>1. PLACE OF DEATH</b>                                                                                                                                                                                                                                                        |                                     |                                                                                                               |                                                 | <b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>                                |                                                                            |                                                                       |                                                   |
| COUNTY <u>Allegany</u>                                                                                                                                                                                                                                                          |                                     | STATE <u>Maryland</u> COUNTY <u>Alle any</u>                                                                  |                                                 | CITY (If outside corporate limits, write RURAL and give nearest town)       |                                                                            | CITY (If outside corporate limits, write RURAL and give nearest town) |                                                   |
| TOWN <u>Cumberland</u>                                                                                                                                                                                                                                                          |                                     | LENGTH OF STAY (in this place) <u>70 yrs</u>                                                                  |                                                 | TOWN <u>Cumberland</u>                                                      |                                                                            | TOWN <u>Cumberland</u>                                                |                                                   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>216 Davidson St.</u>                                                                                                                                                                                                               |                                     |                                                                                                               |                                                 | STREET ADDRESS (If rural give location) <u>216 Davidson, St.</u>            |                                                                            |                                                                       |                                                   |
| <b>3. NAME OF DECEASED</b><br>(Type or Print) <u>Clarence David Walker</u>                                                                                                                                                                                                      |                                     |                                                                                                               |                                                 | <b>4. DATE OF DEATH</b> (Month) (Day) (Year)<br><u>Jan. 24 1956</u>         |                                                                            |                                                                       |                                                   |
| <b>5. SEX</b><br><u>M</u>                                                                                                                                                                                                                                                       | <b>6. COLOR OR RACE</b><br><u>W</u> | <b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b><br><u>Widowed</u>                                     | <b>8. DATE OF BIRTH</b><br><u>Aug. 30, 1883</u> | <b>9. AGE last birthday</b><br><u>76 72 yrs.</u>                            | <b>IF UNDER 1 YEAR</b><br>Months Days                                      | <b>IF UNDER 24 HRS.</b><br>Hours Min.                                 |                                                   |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Painter B&amp;O Railroad</u>                                                                                                                                              |                                     |                                                                                                               | <b>10b. KIND OF BUSINESS OR INDUSTRY</b>        |                                                                             | <b>11. BIRTHPLACE</b> (State or foreign country)<br><u>Cumberland, Md.</u> |                                                                       | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>USA</u> |
| <b>13. FATHER'S NAME</b><br><u>David Walker</u>                                                                                                                                                                                                                                 |                                     |                                                                                                               |                                                 | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Lucy V. Litzenburg</u>                |                                                                            |                                                                       |                                                   |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u>                                                                                                                                                                                                |                                     | <b>16. SOCIAL SECURITY NO.</b><br><u>705-05-4559</u>                                                          |                                                 | <b>17. INFORMANT &amp; ADDRESS</b><br><u>Martha Walker- Cumberland, Md.</u> |                                                                            |                                                                       |                                                   |
| <b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>                                                                                                                                                                                                                       |                                     |                                                                                                               |                                                 |                                                                             |                                                                            | <b>18. MEDICAL CERTIFICATION</b>                                      |                                                   |
| <b>334X</b> IMMEDIATE CAUSE (A) <u>apoplectic stroke</u>                                                                                                                                                                                                                        |                                     |                                                                                                               |                                                 |                                                                             |                                                                            | INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>                         |                                                   |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>arterial hypertension</u>                                                                                                                                                                                                                     |                                     |                                                                                                               |                                                 |                                                                             |                                                                            | <u>10 years</u>                                                       |                                                   |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>arteriosclerosis</u>                                                                                                                                                |                                     |                                                                                                               |                                                 |                                                                             |                                                                            | <u>10 years</u>                                                       |                                                   |
| <b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>                                                                                                                                                     |                                     |                                                                                                               |                                                 |                                                                             |                                                                            |                                                                       |                                                   |
| <b>19a. DATE OF OPERATION</b>                                                                                                                                                                                                                                                   |                                     |                                                                                                               |                                                 | <b>19b. MAJOR FINDINGS OF OPERATION</b>                                     |                                                                            |                                                                       |                                                   |
| <b>20. AUTOPSY?</b><br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                 |                                     |                                                                                                               |                                                 |                                                                             |                                                                            |                                                                       |                                                   |
| <b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>                                                                                                                       |                                     | <b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>                                 |                                                 | <b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)         |                                                                            |                                                                       |                                                   |
| <b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) <u>M.</u>                                                                                                                                                                                                                |                                     | <b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |                                                 | <b>21f. HOW DID INJURY OCCUR?</b>                                           |                                                                            |                                                                       |                                                   |
| <b>22. I hereby certify that I attended the deceased from <u>1-23-</u> 19 <u>56</u>, to <u>1-24-</u> 19 <u>56</u>, that I last saw the deceased alive on <u>1-23-</u> 19 <u>56</u>, and that death occurred at <u>11 A</u> M, from the causes and on the date stated above.</b> |                                     |                                                                                                               |                                                 |                                                                             |                                                                            |                                                                       |                                                   |
| <b>SIGNATURE</b> <u>L. H. Morris</u>                                                                                                                                                                                                                                            |                                     |                                                                                                               |                                                 | <b>DATE SIGNED</b> <u>1-26-56</u>                                           |                                                                            |                                                                       |                                                   |
| <b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b><br><u>Burial</u>                                                                                                                                                                                                                |                                     |                                                                                                               |                                                 | <b>DATE THEREOF</b><br><u>1/27/56</u>                                       |                                                                            | <b>NAME OF CEMETERY OR CREMATORY</b><br><u>Rose Hill Cem</u>          |                                                   |
| <b>24. REC'D BY REGISTRAR</b><br><u>Jan. 27, 1956</u>                                                                                                                                                                                                                           |                                     |                                                                                                               |                                                 | <b>REGISTRAR'S SIGNATURE</b><br><u>Walter R. Frank, M.D.</u>                |                                                                            | <b>25. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>H. Lee Silcox</u>       |                                                   |
|                                                                                                                                                                                                                                                                                 |                                     |                                                                                                               |                                                 | <b>LOCATION (City, town, or county)</b><br><u>Cumberland, Md.</u>           |                                                                            | <b>ADDRESS</b><br><u>Cumberland, Md.</u>                              |                                                   |

ANALYST

RECEIVED

1 Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

64 CERTIFICATE OF DEATH

00095

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third-copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

|                                                                                                                                                                                                                                           |                   |                                                                                                                                                          |                                     |                                                                                  |                                                                 |                                                                                  |                                     |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|----------------------------------------------------------------------------------|-----------------------------------------------------------------|----------------------------------------------------------------------------------|-------------------------------------|
| 1. PLACE OF DEATH                                                                                                                                                                                                                         |                   |                                                                                                                                                          |                                     | 2. USUAL RESIDENCE (HOME) OF DECEASED                                            |                                                                 |                                                                                  |                                     |
| COUNTY ALLEGANY                                                                                                                                                                                                                           |                   | MARYLAND                                                                                                                                                 |                                     | STATE MARYLAND                                                                   |                                                                 | COUNTY ALLEGANY                                                                  |                                     |
| CITY (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND                                                                                                                                                          |                   | LENGTH OF STAY 11 DAYS                                                                                                                                   |                                     | CITY (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND |                                                                 |                                                                                  |                                     |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL                                                                                                                                                                               |                   |                                                                                                                                                          |                                     | STREET ADDRESS (If rural give location) 122 W. FIRST                             |                                                                 |                                                                                  |                                     |
| 3. NAME OF DECEASED (Type or Print) FRANK (First) C (Middle) WEAVER (Last)                                                                                                                                                                |                   |                                                                                                                                                          |                                     | 4. DATE OF DEATH (Month) JAN. (Day) 11 (Year) 56                                 |                                                                 |                                                                                  |                                     |
| 5. SEX MALE                                                                                                                                                                                                                               | 6. COLOR OR WHITE | 7. SINGLE, MARRIED, WIDOWER, DIVORCED (Specify) MARRIED                                                                                                  | 8. DATE OF BIRTH FEB. 2, 1899       | 9. AGE last birthday 56 yrs.                                                     | IF UNDER 1 YEAR Months Days                                     |                                                                                  | IF UNDER 24 HRS. Hours Min.         |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOILER MAKER-B&O R.R.                                                                                                                         |                   |                                                                                                                                                          | 10b. KIND OF BUSINESS OR INDUSTRY   |                                                                                  | 11. BIRTHPLACE (State or foreign country) PENNSYLVANIA Rockwood |                                                                                  | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME JOHN WEAVER                                                                                                                                                                                                             |                   |                                                                                                                                                          |                                     | 14. MOTHER'S MAIDEN NAME GERTRUDE YOUNKIN                                        |                                                                 |                                                                                  |                                     |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, (chk.)) (If Yes, give war or dates of service) No                                                                                                                                  |                   |                                                                                                                                                          | 16. SOCIAL SECURITY NO. 705-00-9511 |                                                                                  | 17. INFORMANT & ADDRESS Sarah Weaver 122 W. 1st. St.            |                                                                                  |                                     |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH                                                                                                                                                                                        |                   |                                                                                                                                                          |                                     |                                                                                  |                                                                 | 18. MEDICAL CERTIFICATION                                                        |                                     |
| 151X IMMEDIATE CAUSE (A) Metastatic Carcinoma of stomach                                                                                                                                                                                  |                   |                                                                                                                                                          |                                     |                                                                                  |                                                                 | INTERVAL BETWEEN ONSET AND DEATH 6 1/2 months                                    |                                     |
| ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) (C)                                                                                                   |                   |                                                                                                                                                          |                                     |                                                                                  |                                                                 |                                                                                  |                                     |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Coronary Artery Disease and Myocardial Disease                                                                       |                   |                                                                                                                                                          |                                     |                                                                                  |                                                                 | 4 1/2 years                                                                      |                                     |
| 19a. DATE OF OPERATION July 28, 1955                                                                                                                                                                                                      |                   | 19b. MAJOR FINDINGS OF OPERATION Extensive Carcinoma of stomach                                                                                          |                                     |                                                                                  |                                                                 | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                     |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                        |                   | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)                                                                                   |                                     | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)                     |                                                                 |                                                                                  |                                     |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)                                                                                                                                                                                    |                   | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                                     | 21f. HOW DID INJURY OCCUR?                                                       |                                                                 |                                                                                  |                                     |
| 22. I hereby certify that I attended the deceased from November 29, 1955, to January 11, 1956, that I last saw the deceased alive on January 10, 1956, and that death occurred at 4:22 A.M. from the causes and on the date stated above. |                   |                                                                                                                                                          |                                     |                                                                                  |                                                                 |                                                                                  |                                     |
| SIGNATURE                                                                                                                                                                                                                                 |                   | ADDRESS (Street, city, town, state)                                                                                                                      |                                     | DATE SIGNED                                                                      |                                                                 |                                                                                  |                                     |
| M.D. 50 Pershing St., Cumberland, Md.                                                                                                                                                                                                     |                   |                                                                                                                                                          |                                     | 1/11/56                                                                          |                                                                 |                                                                                  |                                     |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial                                                                                                                                                                                           |                   | DATE THEREOF I-14-56                                                                                                                                     |                                     | NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park                              |                                                                 | LOCATION (City, town, or county) (State) Cumberland, Md.                         |                                     |
| 24. REC'D BY REGISTRAR                                                                                                                                                                                                                    |                   | REGISTRAR'S SIGNATURE                                                                                                                                    |                                     | 25. FUNERAL DIRECTOR'S SIGNATURE                                                 |                                                                 | ADDRESS                                                                          |                                     |
| Jan. 14, 1956                                                                                                                                                                                                                             |                   | Winters R. Frank, M.D.                                                                                                                                   |                                     | James F. Scarpelli                                                               |                                                                 | Cumberland, Md.                                                                  |                                     |

# CERTIFICATE OF DEATH

ALLEGY  
TUMULTUOUS  
11 DAYS  
EVEN CHAPERLAIN

CRISTAL HOSPITAL  
1057, FIRST

BRANK  
MENANT  
11

WHITE  
WIND  
FEB. 2, 1956

JOHN MEYER  
COLLECTOR-TAKEN-NO B.M.  
PERCY WAIN  
CENTRAL YOUNG

BUREAU V. 5

JAN 17 1956

RECEIVED

PHOTOGRAPH

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

WILLIAM CORPORATE LIMITS

65

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00096

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

|                                                                                                                                                                                                                                                                  |                               |                                                                                                        |                                   |                                                                                              |                 |                                                                        |                  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|--------------------------------------------------------------------------------------------------------|-----------------------------------|----------------------------------------------------------------------------------------------|-----------------|------------------------------------------------------------------------|------------------|
| <b>1. PLACE OF DEATH</b>                                                                                                                                                                                                                                         |                               |                                                                                                        |                                   | <b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>                                                 |                 |                                                                        |                  |
| COUNTY <u>Allegany County</u>                                                                                                                                                                                                                                    |                               | STATE <u>Maryland</u> COUNTY <u>Allegany</u>                                                           |                                   | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland, Md.</u> |                 | TOWN <u>Cumberland, Md.</u>                                            |                  |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland,</u>                                                                                                                                                                         |                               | LENGTH OF STAY (In this place) <u>Lifetime</u>                                                         |                                   | STREET ADDRESS (If rural give location) <u>229 Cecelia St.</u>                               |                 | HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u> |                  |
| <b>3. NAME OF DECEASED</b> (Type or Print) <u>Virginia A. Welsh</u>                                                                                                                                                                                              |                               |                                                                                                        |                                   | <b>4. DATE OF DEATH</b> (Month) <u>Jan.</u> (Day) <u>6.</u> (Year) <u>1956.</u>              |                 |                                                                        |                  |
| 5. SEX <u>Female</u>                                                                                                                                                                                                                                             | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>                                         | 8. DATE OF BIRTH <u>2/20-1901</u> | 9. AGE last birthday <u>54</u> yrs.                                                          | IF UNDER 1 YEAR |                                                                        | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>R.N.</u>                                                                                                                                                          |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Registered Nurse</u>                                              |                                   | 11. BIRTHPLACE (State or foreign country) <u>Maryland Cumberland</u>                         |                 | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                             |                  |
| 13. FATHER'S NAME <u>Charles J. Welsh</u>                                                                                                                                                                                                                        |                               |                                                                                                        |                                   | 14. MOTHER'S MAIDEN NAME <u>Annie Lavin</u>                                                  |                 |                                                                        |                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)                                                                                                                                                 |                               | 16. SOCIAL SECURITY NO. <u>None</u>                                                                    |                                   | 17. INFORMANT & ADDRESS <u>Edward Welsh Cumberland, Md.</u>                                  |                 |                                                                        |                  |
| <b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>                                                                                                                                                                                                        |                               |                                                                                                        |                                   | <b>18. MEDICAL CERTIFICATION</b>                                                             |                 |                                                                        |                  |
| IMMEDIATE CAUSE (A) <u>277x Cerebral Hemorrhage</u>                                                                                                                                                                                                              |                               |                                                                                                        |                                   | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>                                               |                 |                                                                        |                  |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Vascular Disease?</u>                                                                                                                                                                                             |                               |                                                                                                        |                                   |                                                                                              |                 |                                                                        |                  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Obesity (Cushing's Type) all her life.</u>                                                                                                           |                               |                                                                                                        |                                   |                                                                                              |                 |                                                                        |                  |
| 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes mellitus</u>                                                                                                                   |                               |                                                                                                        |                                   | ?                                                                                            |                 |                                                                        |                  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                           |                               | 19b. MAJOR FINDINGS OF OPERATION                                                                       |                                   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |                 |                                                                        |                  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                               |                               | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)                                 |                                   | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)                                 |                 |                                                                        |                  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)                                                                                                                                                                                                             |                               | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |                                   | 21f. HOW DID INJURY OCCUR?                                                                   |                 |                                                                        |                  |
| <b>22. I hereby certify that I attended the deceased from</b> <u>3 Jan. 1956</u> , to <u>6 Jan. 1956</u> , that I last saw the deceased alive on <u>6 Jan. 1956</u> , and that death occurred at <u>7:15 P</u> .M, from the causes and on the date stated above. |                               |                                                                                                        |                                   |                                                                                              |                 |                                                                        |                  |
| SIGNATURE <u>Mr. Alfred Van Amer</u>                                                                                                                                                                                                                             |                               |                                                                                                        |                                   | ADDRESS (Street, city, town, state) <u>Cumberland, Md.</u>                                   |                 | DATE SIGNED <u>8 Jan. 56</u>                                           |                  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>                                                                                                                                                                                                           |                               | DATE THEREOF <u>I-10-56</u>                                                                            |                                   | NAME OF CEMETERY OR CREMATORY <u>St. Patrick Cem.</u>                                        |                 | LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>        |                  |
| 24. REC'D BY REGISTRAR <u>1-10-56</u>                                                                                                                                                                                                                            |                               | REGISTRAR'S SIGNATURE <u>Walter R. Priddy</u>                                                          |                                   | 25. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli</u>                                   |                 | ADDRESS <u>Cumberland, Md.</u>                                         |                  |





66

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After 10 days the certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

|                                                                                                                                                                                                                               |                  |                                                                        |                  |                                                                       |                 |                                                                       |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------|-----------------|-----------------------------------------------------------------------|--|
| 1. PLACE OF DEATH                                                                                                                                                                                                             |                  |                                                                        |                  | 2. USUAL RESIDENCE (HOME) OF DECEASED                                 |                 |                                                                       |  |
| COUNTY <b>Allegany</b>                                                                                                                                                                                                        |                  | STATE <b>Maryland</b> COUNTY <b>Allegany</b>                           |                  | CITY (If outside corporate limits, write RURAL and give nearest town) |                 | CITY (If outside corporate limits, write RURAL and give nearest town) |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)                                                                                                                                                         |                  | LENGTH OF STAY (in this place)                                         |                  | TOWN                                                                  |                 | TOWN                                                                  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS                                                                                                                                                                                     |                  | STREET ADDRESS                                                         |                  | HOSPITAL OR INSTITUTION OR STREET ADDRESS                             |                 | STREET ADDRESS                                                        |  |
| 3. NAME OF DECEASED (Type or Print)                                                                                                                                                                                           |                  | (First) (Middle) (Last)                                                |                  | 4. DATE OF DEATH                                                      |                 | (Month) (Day) (Year)                                                  |  |
| John F. Wempe                                                                                                                                                                                                                 |                  |                                                                        |                  | January 12, 1956                                                      |                 |                                                                       |  |
| 5. SEX                                                                                                                                                                                                                        | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)                       | 8. DATE OF BIRTH | 9. AGE last birthday                                                  | IF UNDER 1 YEAR | IF UNDER 24 HRS.                                                      |  |
| Male                                                                                                                                                                                                                          | White            | Widower                                                                | 7/6/1872         | 83 yrs.                                                               | Months Days     | Hours Min.                                                            |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                   |                  | 10b. KIND OF BUSINESS OR INDUSTRY                                      |                  | 11. BIRTHPLACE (State or foreign country)                             |                 | 12. CITIZEN OF WHAT COUNTRY?                                          |  |
| Retired-Janitor-Eve. Times News                                                                                                                                                                                               |                  | Cumberland, Maryland                                                   |                  | U. S. A.                                                              |                 |                                                                       |  |
| 13. FATHER'S NAME                                                                                                                                                                                                             |                  |                                                                        |                  | 14. MOTHER'S MAIDEN NAME                                              |                 |                                                                       |  |
| Francis Wempe                                                                                                                                                                                                                 |                  |                                                                        |                  | Mary Koelker                                                          |                 |                                                                       |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)                                                                                                                                                               |                  | 16. SOCIAL SECURITY NO.                                                |                  | 17. INFORMANT & ADDRESS                                               |                 |                                                                       |  |
| No                                                                                                                                                                                                                            |                  |                                                                        |                  | Allegany County Infirmary Records                                     |                 |                                                                       |  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH                                                                                                                                                                            |                  |                                                                        |                  | 18. MEDICAL CERTIFICATION                                             |                 |                                                                       |  |
| 334X IMMEDIATE CAUSE (A)                                                                                                                                                                                                      |                  |                                                                        |                  | Pulmonary Hypostasis                                                  |                 |                                                                       |  |
| ANTECEDENT CAUSE(S) DUE TO                                                                                                                                                                                                    |                  |                                                                        |                  | Chronic Myocarditis                                                   |                 |                                                                       |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO                                                                                                                          |                  |                                                                        |                  | Cerebral Arteriosclerosis                                             |                 |                                                                       |  |
| (C)                                                                                                                                                                                                                           |                  |                                                                        |                  | Senile psychosis                                                      |                 |                                                                       |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                        |                  |                                                                        |                  | 19b. MAJOR FINDINGS OF OPERATION                                      |                 |                                                                       |  |
|                                                                                                                                                                                                                               |                  |                                                                        |                  |                                                                       |                 |                                                                       |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                              |                  | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) |                  | 21c. WHERE DID INJURY OCCUR? (City or town)                           |                 | (County) (State)                                                      |  |
|                                                                                                                                                                                                                               |                  |                                                                        |                  |                                                                       |                 |                                                                       |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)                                                                                                                                                                               |                  | 21e. INJURY OCCURRED White et work Not white et work                   |                  | 21f. HOW DID INJURY OCCUR?                                            |                 |                                                                       |  |
|                                                                                                                                                                                                                               |                  |                                                                        |                  |                                                                       |                 |                                                                       |  |
| 22. I hereby certify that I attended the deceased from Jan. 28, 1956, to Jan. 12, 1956, that I last saw the deceased alive on Jan. 13, 1956, and that death occurred at 8:30 M. from the causes and on the date stated above. |                  |                                                                        |                  |                                                                       |                 |                                                                       |  |
| SIGNATURE                                                                                                                                                                                                                     |                  |                                                                        |                  | ADDRESS (Street, city, town, state)                                   |                 | DATE SIGNED                                                           |  |
| James E. McLean M.D.                                                                                                                                                                                                          |                  |                                                                        |                  | 49 Greene St.                                                         |                 | 1-13-56                                                               |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                      |                  | DATE THEREOF                                                           |                  | NAME OF CEMETERY OR CREMATORY                                         |                 | LOCATION (City, town, or county)                                      |  |
| Burial                                                                                                                                                                                                                        |                  | I-16-56                                                                |                  | St. Peter & Paul Cem.                                                 |                 | Cumberland, Md.                                                       |  |
| 24. REC'D BY REGISTRAR                                                                                                                                                                                                        |                  | REGISTRAR'S SIGNATURE                                                  |                  | 25. FUNERAL DIRECTOR'S SIGNATURE                                      |                 | ADDRESS                                                               |  |
| Jan. 16, 1956                                                                                                                                                                                                                 |                  | Winter R. Bank, M.D.                                                   |                  | James F. Scarpelli                                                    |                 | Cumberland, Md.                                                       |  |

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

File No.

1. NAME OF DECEASED OR DECLARED

2. PLACE OF BIRTH

3. SEX

4. AGE

5. DATE OF DEATH

6. TIME

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF DECEASED

13. SIGNATURE OF DECEASED

14. SIGNATURE OF DECEASED

15. SIGNATURE OF DECEASED

16. SIGNATURE OF DECEASED

17. SIGNATURE OF DECEASED

18. SIGNATURE OF DECEASED

19. SIGNATURE OF DECEASED

20. SIGNATURE OF DECEASED

21. SIGNATURE OF DECEASED

22. SIGNATURE OF DECEASED

23. SIGNATURE OF DECEASED

24. SIGNATURE OF DECEASED

25. SIGNATURE OF DECEASED

BUREAU V. 8

JAN 17 1956

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00098

86

## CERTIFICATE OF DEATH

Reg. Dist. No. 6

|                                                                                                                                                                                                                                      |                                         |                                                                               |                                                 |                                                                                            |                                       |                                                                  |                                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------|--------------------------------------------------------------------------------------------|---------------------------------------|------------------------------------------------------------------|---------------------------------------|
| <b>1. PLACE OF DEATH</b>                                                                                                                                                                                                             |                                         |                                                                               |                                                 | <b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>                                               |                                       |                                                                  |                                       |
| COUNTY <b>Allegany</b>                                                                                                                                                                                                               |                                         | STATE <b>Md.</b>                                                              |                                                 | COUNTY <b>Baltimore</b>                                                                    |                                       |                                                                  |                                       |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br><b>43 Westernport</b>                                                                                                                                       |                                         | LENGTH OF STAY (In this place)<br><b>1 week</b>                               |                                                 | CITY (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>  |                                       | <b>3V01-4</b>                                                    |                                       |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><b>Ross Street</b>                                                                                                                                                                      |                                         | STREET ADDRESS (If rural give location)<br><b>6211 Catalpha Road</b>          |                                                 |                                                                                            |                                       |                                                                  |                                       |
| <b>3. NAME OF DECEASED</b> (First) (Middle) (Last)<br><b>Arthur Coyle Wiley</b>                                                                                                                                                      |                                         |                                                                               |                                                 | <b>4. DATE OF DEATH</b> (Month) (Day) (Year)<br><b>Jan. 11, 1956</b>                       |                                       |                                                                  |                                       |
| <b>5. SEX</b><br><b>Male</b>                                                                                                                                                                                                         | <b>6. COLOR OR RACE</b><br><b>White</b> | <b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b><br><b>Married</b>     | <b>8. DATE OF BIRTH</b><br><b>Aug. 23, 1902</b> | <b>9. AGE last birthday</b><br><b>53</b> yrs.                                              | <b>IF UNDER 1 YEAR</b><br>Months Days |                                                                  | <b>IF UNDER 24 HRS.</b><br>Hours Min. |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if (Retired) <b>B. &amp; O. Ry. Engineer</b>                                                                                                  |                                         | <b>10b. KIND OF BUSINESS OR INDUSTRY</b>                                      |                                                 | <b>11. BIRTHPLACE</b> (State or foreign country)<br><b>Deer Park, Md.</b>                  |                                       | <b>12. CITIZEN OF WHAT COUNTRY?</b>                              |                                       |
| <b>13. FATHER'S NAME</b><br><b>Jacob Wiley</b>                                                                                                                                                                                       |                                         |                                                                               |                                                 | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Elizabeth Steiding</b>                               |                                       |                                                                  |                                       |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)<br><b>No</b>                                                                                                                                                  |                                         | <b>16. SOCIAL SECURITY NO.</b><br><b>236-03-2434</b>                          |                                                 | <b>17. INFORMANT &amp; ADDRESS</b><br><b>Mrs. Pearl W. Wiley (Wife)</b>                    |                                       |                                                                  |                                       |
| <b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>                                                                                                                                                                           |                                         |                                                                               |                                                 |                                                                                            |                                       | <b>18. MEDICAL CERTIFICATION</b>                                 |                                       |
| <b>260X IMMEDIATE CAUSE (A)</b> <b>Chronic Nephritis</b>                                                                                                                                                                             |                                         |                                                                               |                                                 |                                                                                            |                                       | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><b>6 mo</b>           |                                       |
| <b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>Diabetes mellitus</b>                                                                                                                                                                       |                                         |                                                                               |                                                 |                                                                                            |                                       | <b>1930.</b>                                                     |                                       |
| <b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)</b>                                                                                                                      |                                         |                                                                               |                                                 |                                                                                            |                                       |                                                                  |                                       |
| <b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>                                                                                                          |                                         |                                                                               |                                                 |                                                                                            |                                       |                                                                  |                                       |
| <b>19a. DATE OF OPERATION</b>                                                                                                                                                                                                        |                                         | <b>19b. MAJOR FINDINGS OF OPERATION</b>                                       |                                                 | <b>20. AUTOPSY?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                       |                                                                  |                                       |
| <b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>                                                                            |                                         | <b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b> |                                                 | <b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)                        |                                       |                                                                  |                                       |
| <b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                     |                                         | <b>21f. HOW DID INJURY OCCUR?</b>                                             |                                                 |                                                                                            |                                       |                                                                  |                                       |
| <b>22. I hereby certify that I attended the deceased from July 25, 1935, to Jan 11, 1956, that I last saw the deceased alive on Jan 11, 1956, and that death occurred at 2:30 P.M. from the causes and on the date stated above.</b> |                                         |                                                                               |                                                 |                                                                                            |                                       |                                                                  |                                       |
| <b>SIGNATURE</b> <i>P. Berry</i>                                                                                                                                                                                                     |                                         |                                                                               |                                                 | <b>ADDRESS</b> (Street, city, town, state) <i>Piedmont W. Va.</i>                          |                                       | <b>DATE SIGNED</b> <i>1/12/56</i>                                |                                       |
| <b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b><br><b>Burial</b>                                                                                                                                                                     |                                         | <b>DATE THEREOF</b><br><b>1/14/56</b>                                         |                                                 | <b>NAME OF CEMETERY OR CREMATORY</b><br><b>Queens Point Cem.</b>                           |                                       | <b>LOCATION (City, town, or county)</b><br><b>Keyser, W. Va.</b> |                                       |
| <b>24. REC'D BY REGISTRAR</b><br><b>DATE</b> <i>1-13-56</i>                                                                                                                                                                          |                                         | <b>REGISTRAR'S SIGNATURE</b><br><i>Mr. John C. Kelly</i>                      |                                                 | <b>25. FUNERAL DIRECTOR'S SIGNATURE</b><br><i>B. H. Markwood</i>                           |                                       | <b>ADDRESS</b><br><i>Keyser, W. Va.</i>                          |                                       |

# CERTIFICATE OF DEATH

80

STATE OF NEW YORK DEPARTMENT OF HEALTH - ALBANY

FILE NO.

1. NAME OF DECEASED (Print or Write)

2. SEX

3. AGE

4. OCCUPATION

5. PLACE OF BIRTH

6. DATE OF BIRTH

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. NAME OF FUNERAL HOME

12. NAME OF BURIAL PLACE

13. DATE OF BURIAL

14. NAME OF WITNESS

15. NAME OF WITNESS

16. NAME OF WITNESS

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BUREAU V. S.

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 9

|                                                                                                                                          |                                |                                                                 |                                       |                                                                                   |                 |                                                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|-----------------------------------------------------------------|---------------------------------------|-----------------------------------------------------------------------------------|-----------------|------------------------------------------------------------|--|
| 1. PLACE OF DEATH:                                                                                                                       |                                |                                                                 |                                       | 2. USUAL RESIDENCE (HOME) OF DECEASED:                                            |                 |                                                            |  |
| COUNTY <u>Allegany</u>                                                                                                                   |                                | MARYLAND                                                        |                                       | STATE <u>Md</u>                                                                   |                 | COUNTY <u>Allegany</u>                                     |  |
| CITY (If outside corporate limits, write RURAL or and give nearest town)                                                                 |                                | LENGTH OF STAY (in this place)                                  |                                       | CITY (If outside corporate limits write RURAL and give nearest town)              |                 |                                                            |  |
| 12 TOWN <u>Frostburg</u>                                                                                                                 |                                | 2 mo.                                                           |                                       | TOWN <u>Rural) Zihlman</u> X                                                      |                 |                                                            |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u>                                                                         |                                |                                                                 |                                       | STREET ADDRESS <u>R.F.D.#2 (If rural, give location)</u><br><u>Frostburg, Md.</u> |                 |                                                            |  |
| 3. NAME OF DECEASED: (First) <u>Roy</u>                                                                                                  |                                | (Middle) <u>R.</u>                                              |                                       | (Last) <u>Winebrenner</u>                                                         |                 | 4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 14 19 56</u> |  |
| 5. SEX: <u>male</u>                                                                                                                      | 6. COLOR OR RACE: <u>white</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u> | 8. DATE OF BIRTH: <u>Nov. 17-1894</u> | 9. AGE last birthday: <u>61</u> yrs.                                              | IF UNDER 1 YEAR | IF UNDER 24 HRS.                                           |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Press operator, fire brick, Refractories</u> |                                | 10b. KIND OF BUSINESS OR INDUSTRY: <u>Big Savage</u>            |                                       | 11. BIRTHPLACE (State or foreign country): <u>Mt. Savage, Md.</u>                 |                 | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                 |  |
| 13. FATHER'S NAME: <u>Thomas Winebrenner</u>                                                                                             |                                |                                                                 |                                       | 14. MOTHER'S MAIDEN NAME: <u>Ida Porter</u>                                       |                 |                                                            |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)                                                                           |                                | 16. SOCIAL SECURITY No.: <u>212-10-6309</u>                     |                                       | 17. INFORMANT & ADDRESS: <u>(wife) Cecelia Winebrenner, Zihlman, Md.</u>          |                 |                                                            |  |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                        |  |                                                |  |                                                                                  |  |
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| 18. MEDICAL CERTIFICATION                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                        |  |                                                |  | INTERVAL BETWEEN ONSET AND DEATH                                                 |  |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                        |  |                                                |  | ?                                                                                |  |
| 151X Immediate cause (a) <u>Carcinoma of the stomach also had</u>                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                        |  |                                                |  | about 2 days.                                                                    |  |
| Antecedent cause(s) (b) <u>Lobar pneumonia</u>                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                        |  |                                                |  |                                                                                  |  |
| Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                        |  |                                                |  |                                                                                  |  |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  |                                                |  |                                                                                  |  |
| 19a. DATE OF OPERATION:                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 19b. MAJOR FINDING OF OPERATION:                                                                       |  |                                                |  |                                                                                  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                             |  | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY                                 |  | 21c. (City or town) (County) (State)           |  | 20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR?                     |  |                                                                                  |  |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |  |                                                                                                        |  |                                                |  |                                                                                  |  |
| SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | NAME OF CEMETERY OR CREMATORY                                                                          |  | LOCATION (City, town, or county)               |  | DATE SIGNED                                                                      |  |
| <u>H.V. Deming M.D.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | <u>Frostburg Memorial Park, Frostburg, Md.</u>                                                         |  | <u>Frostburg, Md.</u>                          |  | <u>Jan. 14-1956</u>                                                              |  |
| 23. BURIAL, CREMATION, REMOVAL (Specify):                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | DATE THEREOF                                                                                           |  | LOCATION (City, town, or county)               |  | (State)                                                                          |  |
| <u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | <u>1-16-56</u>                                                                                         |  | <u>Frostburg Memorial Park, Frostburg, Md.</u> |  | <u>Md.</u>                                                                       |  |
| DATE REC'D BY LOCAL REG.                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | REGISTRAR'S SIGNATURE                                                                                  |  | 24. FUNERAL DIRECTOR                           |  | ADDRESS                                                                          |  |
| <u>1-16-56</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | <u>Wm. Harry A. Roe</u>                                                                                |  | <u>Joseph R. Durst,</u>                        |  | <u>Frostburg, Md.</u>                                                            |  |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 18 1956

RECEIVED

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

67

|                                                                                                                                                                                                                     |                  |                                                                                                        |                  |                                                                                                    |                 |                                                                       |                  |
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| 1. PLACE OF DEATH                                                                                                                                                                                                   |                  |                                                                                                        |                  | 2. USUAL RESIDENCE (HOME) OF DECEASED                                                              |                 |                                                                       |                  |
| COUNTY <u>Allegheny</u>                                                                                                                                                                                             |                  | MARYLAND                                                                                               |                  | STATE <u>Maryland</u>                                                                              |                 | COUNTY <u>Allegheny</u>                                               |                  |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)                                                                                                                                            |                  | LENGTH OF STAY (in this place)                                                                         |                  | CITY (If outside corporate limits, write RURAL and give nearest town)                              |                 |                                                                       |                  |
| 02 TOWN <u>Cumberland,</u>                                                                                                                                                                                          |                  |                                                                                                        |                  | 02 TOWN <u>Cumberland,</u>                                                                         |                 |                                                                       |                  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS                                                                                                                                                                           |                  |                                                                                                        |                  | STREET ADDRESS (If rural give location)                                                            |                 |                                                                       |                  |
| 02 8 N. Johnson St.,                                                                                                                                                                                                |                  |                                                                                                        |                  | 8 N. Johnson St.,                                                                                  |                 |                                                                       |                  |
| 3. NAME OF DECEASED (Type or Print)                                                                                                                                                                                 |                  |                                                                                                        |                  | 4. DATE OF DEATH                                                                                   |                 |                                                                       |                  |
| (First) (Middle) (Last)                                                                                                                                                                                             |                  |                                                                                                        |                  | (Month) (Day) (Year)                                                                               |                 |                                                                       |                  |
| <u>WILLIAM</u> <u>DERWOOD</u> <u>WOLFORD</u>                                                                                                                                                                        |                  |                                                                                                        |                  | Jan. 15, 1956                                                                                      |                 |                                                                       |                  |
| 5. SEX                                                                                                                                                                                                              | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)                                                        | 8. DATE OF BIRTH | 9. AGE last birthday yrs.                                                                          | IF UNDER 1 YEAR |                                                                       | IF UNDER 24 HRS. |
| Male                                                                                                                                                                                                                | White            | Married                                                                                                | Nov. 16, 1910    | 45                                                                                                 | Months          | Days                                                                  | Hours Min.       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                         |                  | 10b. KIND OF BUSINESS OR INDUSTRY                                                                      |                  | 11. BIRTHPLACE (State or foreign country)                                                          |                 | 12. CITIZEN OF WHAT COUNTRY?                                          |                  |
| Salesman                                                                                                                                                                                                            |                  | Sears Roebuck Co.                                                                                      |                  | Cumberland, Maryland                                                                               |                 | U. S.                                                                 |                  |
| 13. FATHER'S NAME                                                                                                                                                                                                   |                  |                                                                                                        |                  | 14. MOTHER'S MAIDEN NAME                                                                           |                 |                                                                       |                  |
| William O. Wolford                                                                                                                                                                                                  |                  |                                                                                                        |                  | Mina Goshorn                                                                                       |                 |                                                                       |                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)                                                                                                                                                     |                  | 16. SOCIAL SECURITY NO.                                                                                |                  | 17. INFORMANT & ADDRESS                                                                            |                 |                                                                       |                  |
| No,                                                                                                                                                                                                                 |                  |                                                                                                        |                  | Mrs. Dorothy J. Wolford Cumberland, Md.<br>8 N. Johnson St.                                        |                 |                                                                       |                  |
| 18. MEDICAL CERTIFICATION                                                                                                                                                                                           |                  |                                                                                                        |                  |                                                                                                    |                 | INTERVAL BETWEEN ONSET AND DEATH                                      |                  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH                                                                                                                                                                  |                  |                                                                                                        |                  |                                                                                                    |                 |                                                                       |                  |
| 204.1 IMMEDIATE CAUSE (A) <u>Acute Myeloid Leukemia</u>                                                                                                                                                             |                  |                                                                                                        |                  |                                                                                                    |                 |                                                                       |                  |
| ANTECEDENT CAUSE(S) DUE TO                                                                                                                                                                                          |                  |                                                                                                        |                  |                                                                                                    |                 |                                                                       |                  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE                                                                                                                                                      |                  |                                                                                                        |                  |                                                                                                    |                 |                                                                       |                  |
| STATING UNDERLYING CAUSE LAST. DUE TO (C)                                                                                                                                                                           |                  |                                                                                                        |                  |                                                                                                    |                 |                                                                       |                  |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.                                                                                                |                  |                                                                                                        |                  |                                                                                                    |                 |                                                                       |                  |
| 19a. DATE OF OPERATION                                                                                                                                                                                              |                  | 19b. MAJOR FINDINGS OF OPERATION                                                                       |                  |                                                                                                    |                 | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |                  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                  |                  | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)                                 |                  | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)                                       |                 |                                                                       |                  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)                                                                                                                                                                     |                  | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |                  | 21f. HOW DID INJURY OCCUR?                                                                         |                 |                                                                       |                  |
|                                                                                                                                                                                                                     |                  | M.                                                                                                     |                  |                                                                                                    |                 |                                                                       |                  |
| 22. I hereby certify that I attended the deceased from 1/5, 1955, to 1/5, 1956, that I last saw the deceased alive on 1/5, 1956, and that death occurred at 11:35 AM, from the causes end on the date stated above. |                  |                                                                                                        |                  |                                                                                                    |                 |                                                                       |                  |
| SIGNATURE <u>Leo S. Gray Jr.</u>                                                                                                                                                                                    |                  |                                                                                                        |                  | ADDRESS (Street, city, town, state) <u>452 N. Centre St., Cumberland</u> DATE SIGNED <u>1/6/56</u> |                 |                                                                       |                  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                            |                  | DATE THEREOF                                                                                           |                  | NAME OF CEMETERY OR CREMATORY                                                                      |                 | LOCATION (City, town, or county) (State)                              |                  |
| Burial                                                                                                                                                                                                              |                  | 1/18/56                                                                                                |                  | S. S. Peter & Pauls                                                                                |                 | Cumberland, Maryland                                                  |                  |
| 24. REC'D BY REGISTRAR                                                                                                                                                                                              |                  | REGISTRAR'S SIGNATURE                                                                                  |                  | 25. FUNERAL DIRECTOR'S SIGNATURE                                                                   |                 | ADDRESS                                                               |                  |
| Jan. 17, 1956                                                                                                                                                                                                       |                  | <u>Walter L. Hantz, M.D.</u>                                                                           |                  | Charles L. George                                                                                  |                 | Cumberland, Md.                                                       |                  |

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy, of this death certificate assembly should be detached for use as a burial transit permit.

# CERTIFICATE OF DEATH

Form No. 10

1. USUAL RESIDENCE HOME OR PLACE

PLACE OF DEATH

2. DATE OF DEATH

3. TIME OF DEATH

4. CAUSE OF DEATH

5. PLACE OF BURIAL

6. NAME OF FUNERAL HOME

7. NAME OF PHYSICIAN

8. NAME OF WITNESS

9. NAME OF MINISTER

10. NAME OF CHURCH

11. NAME OF CEMETERY

12. NAME OF INTERVIEWER

13. NAME OF REGISTRAR

14. NAME OF CLERK

15. NAME OF ASSISTANT

16. NAME OF OFFICIAL

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265. NAME OF

68  
CERTIFICATE OF DEATH

Reg. Dist. No. 4

|                                                                                                                                                                                                                                                               |                                  |                                                                        |                                          |                                                                                     |                           |                                                                 |                                                      |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|------------------------------------------------------------------------|------------------------------------------|-------------------------------------------------------------------------------------|---------------------------|-----------------------------------------------------------------|------------------------------------------------------|
| 1. PLACE OF DEATH                                                                                                                                                                                                                                             |                                  |                                                                        |                                          | 2. USUAL RESIDENCE (HOME) OF DECEASED                                               |                           |                                                                 |                                                      |
| COUNTY <u>ALLEGANY</u>                                                                                                                                                                                                                                        |                                  | MARYLAND                                                               |                                          | STATE <u>WEST VIRGINIA</u> COUNTY <u>Hardy</u>                                      |                           |                                                                 |                                                      |
| CITY (If outside corporate limits, write RURAL and give nearest town)                                                                                                                                                                                         |                                  | LENGTH OF STAY (in this place)                                         |                                          | CITY (If outside corporate limits, write RURAL and give nearest town)               |                           |                                                                 |                                                      |
| TOWN <u>CUMBERLAND</u>                                                                                                                                                                                                                                        |                                  | <u>4 1/2</u> HRS.                                                      |                                          | TOWN <u>MOOREFIELD</u>                                                              |                           | <u>85X-3</u>                                                    |                                                      |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>MEMORIAL HOSPITAL</u><br><u>MEMORIAL &amp; WARWICK AVES.</u>                                                                                                                                                  |                                  |                                                                        |                                          | STREET ADDRESS (If rural give location)                                             |                           |                                                                 |                                                      |
| 3. NAME OF DECEASED (First) (Middle) (Last)<br><u>BABY</u> <u>GIRL</u> <u>WRIGHT</u>                                                                                                                                                                          |                                  |                                                                        |                                          | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>JAN.</u> <u>30</u> <u>1956</u>          |                           |                                                                 |                                                      |
| 5. SEX<br><u>FEMALE</u>                                                                                                                                                                                                                                       | 6. COLOR OR RACE<br><u>WHITE</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)<br><u>SINGLE</u>      | 8. DATE OF BIRTH<br><u>JAN. 30, 1956</u> | 9. AGE last birthday<br>yrs.                                                        | IF UNDER 1 YEAR<br>Months | IF UNDER 24 HRS.<br>Days                                        | IF UNDER 24 HRS.<br>Hours Min.<br><u>4</u> <u>36</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Infant</u>                                                                                                                                                  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY                                      |                                          | 11. BIRTHPLACE (State or foreign country)<br><u>Cumberland, Maryland</u>            |                           | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                      |                                                      |
| 13. FATHER'S NAME<br><u>GLENN H. WRIGHT, JR.</u>                                                                                                                                                                                                              |                                  |                                                                        |                                          | 14. MOTHER'S MAIDEN NAME<br><u>MARJORIE E. EVANS</u>                                |                           |                                                                 |                                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)<br><u>No</u>                                                                                                                                                                                  |                                  | 16. SOCIAL SECURITY NO.<br><u>None</u>                                 |                                          | 17. INFORMANT & ADDRESS<br><u>MEMORIAL HOSPITAL</u>                                 |                           |                                                                 |                                                      |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH                                                                                                                                                                                                            |                                  |                                                                        |                                          | 18. MEDICAL CERTIFICATION                                                           |                           |                                                                 |                                                      |
| 776X IMMEDIATE CAUSE (A) <u>Pre-maturity - 24 weeks</u>                                                                                                                                                                                                       |                                  |                                                                        |                                          | INTERVAL BETWEEN ONSET AND DEATH<br><u>7 1/2 hr</u>                                 |                           |                                                                 |                                                      |
| ANTECEDENT CAUSE(S) DUE TO                                                                                                                                                                                                                                    |                                  |                                                                        |                                          |                                                                                     |                           |                                                                 |                                                      |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)                                                                                                                                                      |                                  |                                                                        |                                          |                                                                                     |                           |                                                                 |                                                      |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.                                                                                                                                          |                                  |                                                                        |                                          |                                                                                     |                           |                                                                 |                                                      |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                        |                                  | 19b. MAJOR FINDINGS OF OPERATION                                       |                                          | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                           |                                                                 |                                                      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                            |                                  | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) |                                          | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)                        |                           |                                                                 |                                                      |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                                                                                 |                                  | 21e. INJURY OCCURRED                                                   |                                          | 21f. HOW DID INJURY OCCUR?                                                          |                           |                                                                 |                                                      |
|                                                                                                                                                                                                                                                               |                                  |                                                                        |                                          |                                                                                     |                           |                                                                 |                                                      |
| 22. I hereby certify that I attended the deceased from <u>JAN. 30, 1956</u> , to <u>JAN. 30, 1956</u> , that I last saw the deceased alive on <u>JAN. 30, 1956</u> , and that death occurred at <u>9:00AM</u> , from the causes and on the date stated above. |                                  |                                                                        |                                          |                                                                                     |                           |                                                                 |                                                      |
| SIGNATURE<br><u>W. P. Hodges</u>                                                                                                                                                                                                                              |                                  | DATE THEREOF<br><u>Jan 31 - 1956</u>                                   |                                          | NAME OF CEMETERY OR CREMATORY<br><u>Newhouse cemetery</u>                           |                           | LOCATION (City, town, or county) (State)<br><u>Pigg. W. Va.</u> |                                                      |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Buried</u>                                                                                                                                                                                                     |                                  | 24. REC'D BY REGISTRAR<br><u>Jan 31, 1956</u>                          |                                          | 25. FUNERAL DIRECTOR'S SIGNATURE<br><u>Walter R. Frantz, M.D.</u>                   |                           | ADDRESS<br><u>J. Blaine Schoeffel, Petersburg, W. Va.</u>       |                                                      |

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

2060315281





In this corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00102

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

69

|                                                                                                                                                                                                                                                          |                              |                                                                        |                                         |                                                                                                             |                                |                                                                   |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|------------------------------------------------------------------------|-----------------------------------------|-------------------------------------------------------------------------------------------------------------|--------------------------------|-------------------------------------------------------------------|--|
| 1. PLACE OF DEATH                                                                                                                                                                                                                                        |                              |                                                                        |                                         | 2. USUAL RESIDENCE (HOME) OF DECEASED                                                                       |                                |                                                                   |  |
| COUNTY <u>Allegany</u>                                                                                                                                                                                                                                   |                              | MARYLAND                                                               |                                         | STATE <u>Maryland</u>                                                                                       |                                | COUNTY <u>Allegany</u>                                            |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>Cumberland</u>                                                                                                                                                          |                              | LENGTH OF STAY (in this place)<br><u>4yrs. 1mo.</u>                    |                                         | CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>Near Cumberland, rural</u> |                                |                                                                   |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>Sylvan Retreat</u>                                                                                                                                                                                       |                              |                                                                        |                                         | STREET ADDRESS (If rural give location)<br><u>R.F.D. #6, Bowling Green</u>                                  |                                |                                                                   |  |
| 3. NAME OF DECEASED (First) (Middle) (Last)<br><u>Elizzbeth P Wright</u>                                                                                                                                                                                 |                              |                                                                        |                                         | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>January 3 1956</u>                                              |                                |                                                                   |  |
| 5. SEX<br><u>F</u>                                                                                                                                                                                                                                       | 6. COLOR OR RACE<br><u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)<br><u>W</u>           | 8. DATE OF BIRTH<br><u>June 7, 1866</u> | 9. AGE last birthday<br><u>89</u> yrs.                                                                      | IF UNDER 1 YEAR<br>Months Days | IF UNDER 24 HRS.<br>Hours Min.                                    |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>                                                                                                                                          |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own Home</u>                   |                                         | 11. BIRTHPLACE (State or foreign country)<br><u>Frostburg, Md</u>                                           |                                | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u>                   |  |
| 13. FATHER'S NAME<br><u>Phillip Arnold</u>                                                                                                                                                                                                               |                              |                                                                        |                                         | 14. MOTHER'S MAIDEN NAME<br><u>Dorothy Merrill</u>                                                          |                                |                                                                   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)<br><u>No</u>                                                                                                                                                                             |                              | 16. SOCIAL SECURITY NO.<br><u>None</u>                                 |                                         | 17. INFORMANT & ADDRESS<br><u>Mrs. C. S. Eaton, Fairgo, (niece)</u>                                         |                                |                                                                   |  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH                                                                                                                                                                                                       |                              |                                                                        |                                         | 18. MEDICAL CERTIFICATION                                                                                   |                                |                                                                   |  |
| IMMEDIATE CAUSE (A)<br><u>422.2</u>                                                                                                                                                                                                                      |                              |                                                                        |                                         | Pulmonary Hypostasis 24 hrs                                                                                 |                                |                                                                   |  |
| ANTECEDENT CAUSE(S) DUE TO (B)<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)                                                                                                               |                              |                                                                        |                                         | Chronic Myocarditis<br>Cerebral Arteriosclerosis<br>Senile psychosis                                        |                                |                                                                   |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.                                                                                                                                     |                              |                                                                        |                                         | Interval between ONSET AND DEATH<br><u>4 yrs.</u>                                                           |                                |                                                                   |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                   |                              | 19b. MAJOR FINDINGS OF OPERATION                                       |                                         | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                    |                                |                                                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                       |                              | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) |                                         | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)                                                |                                |                                                                   |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)<br>M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                                                                  |                              | 21e. INJURY OCCURRED                                                   |                                         | 21f. HOW DID INJURY OCCUR?                                                                                  |                                |                                                                   |  |
| 22. I hereby certify that I attended the deceased from <u>Jan. 2, 1956</u> , to <u>Jan. 3, 1956</u> , that I last saw the deceased alive on <u>Jan. 2, 1956</u> , and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above. |                              |                                                                        |                                         |                                                                                                             |                                |                                                                   |  |
| SIGNATURE<br><u>James E. McLean</u> M.D.                                                                                                                                                                                                                 |                              |                                                                        |                                         | ADDRESS (Street, city, town, state)<br><u>49 Greene St.</u>                                                 |                                | DATE SIGNED<br><u>1-3-56</u>                                      |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>                                                                                                                                                                                                |                              | DATE THEREOF<br><u>1-5-56</u>                                          |                                         | NAME OF CEMETERY OR CREMATORY<br><u>Hillcrest Cem.</u>                                                      |                                | LOCATION (City, town, or county) (State)<br><u>Cumberland, Md</u> |  |
| 24. REC'D BY REGISTRAR<br><u>Jan. 4, 1956</u>                                                                                                                                                                                                            |                              | REGISTRAR'S SIGNATURE<br><u>Walter L. Lantz, M.D.</u>                  |                                         | 25. FUNERAL DIRECTOR'S SIGNATURE<br><u>Charles L. George</u>                                                |                                | ADDRESS<br><u>Cumberland, Md.</u>                                 |  |

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VS A15C 1-55 10M

JAN 6 1956

RECEIVED

BUREAU V. S.